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Dear Attorneys Beininner and Maddox,

Herein is the fifth compliance report submitted by Jeffrey Geller, M.D., M.P.H. and Mohammed El-Sabaawi, M.D., pursuant to the Settlement Agreement (“Agreement”) entered into between the United States and the State of Vermont (the Agency of Human Services, the Department of Health, the Division of Mental Health and the Vermont State Hospital (“VSH”)), this Agreement resolving the investigation by the United States Department of Justice (“DOJ”) pursuant to the Civil Rights of Institutionalized Persons Act (“CRIPA”), 42 U.S.C. sec 1997.

Our report follows the format of the Agreement with sections of our report numbered and lettered to correspond to the Agreement. Sections generally follow the structure of findings, recommendations, and compliance indication. Recommendations are not explicitly stated when they would derive quite clearly from the findings. Data to substantiate the findings are listed in the body of the report.

The evaluators’ recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in the Agreement.

This report represents the concurred opinion of the two experts in this case.

At the outset we acknowledge the efforts of the staff of VSH in working towards meeting the requirements of the Settlement Agreement. Progress continues to be significant.

## **COMPLIANCE DEFINITIONS**

Compliance with the Agreement requires that VSH demonstrate substantial compliance for each of the requirements. In this report, the Monitors describe the steps taken by VSH to implement corrective measures and the extent to which VSH has met the requirements of the Agreement. It is noted that each provision in the Agreement has a completion date by which substantial compliance is required. Lack of substantial compliance prior to the completion date does not violate the terms of the Agreement.

This report uses the following terms, which have been agreed upon by the parties:

Sustained Compliance (SusC): Substantial compliance has been maintained in the rated provision for a period of at least one year.

Substantial Compliance (SubC): Substantial compliance with all components of the rated provision. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. The number in parentheses after “SubC” is one (1) for the first time at this level and two (2) for the second consecutive time at this level.

Significant Compliance (SigC): Considerable compliance has been achieved on the key components of the rated provision, but refinement of work product remains.

Partial Compliance (PC): Compliance has been achieved on most of the key components of the rated provision, but substantial work remains.

Non-Compliance (NC): Non-compliance with most or all of the components of the Agreement provision.

## **FINDINGS, COMMENTS/RECOMMENDATIONS, AND COMPLIANCE RATINGS**

Sec	Settlement Agreement Terms	Compliance	Finding	Comments and Recommendations
IV.	<p><b>INTEGRATED TREATMENT PLANNING</b></p> <p>By 30 months from the Effective Date hereof, VSH shall provide integrated, individualized protections, services, supports, and treatments (collectively "treatment") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the discipline-specific treatment planning provisions set forth below, VSH shall establish and implement standards, policies, and protocols and/or practices to provide that treatment determinations are consistently coordinated by an interdisciplinary team through integrated treatment planning and embodied in a single, integrated plan.</p>			
A.	<p><b>Interdisciplinary Teams</b></p> <p>By 30 months from the Effective Date hereof, each interdisciplinary team's membership shall be dictated by the particular needs, strengths, and preferences of the individual in the team's care, and, at a minimum, the interdisciplinary team for each individual shall:</p>			
1.	Have as its primary objective the provision of individualized, integrated treatment that optimizes the patient's opportunity for recovery	SigC	VSH now transitioning from Preliminary Treatment Plan to Initial Treatment Plan. Initial Rx Plan	Tick boxes translate at best to <u>very</u> generic interventions – need some means to

Fifth Compliance Report

	and ability to sustain himself/herself in the most appropriate, least restrictive setting, and supports the patient's interests of self determination and independence;		<div> <div> <div></div> <div>9/30/08</div> <div>No RN signature, no evidence RN participated; TRS &amp; SW ok</div> </div> <div> <div></div> <div>10/2/08</div> <div>Psychiatrist and RN, but no TRS or SW after 5 days</div> </div> <div> <div></div> <div>9/26/008</div> <div>Psychiatrist and RN, TRS not until day 7, SW day 5</div> </div> <div> <div></div> <div>9/24/08</div> <div>No RN signature; TRS-6 days; SW day 9</div> </div> <div> <div></div> <div>10/1/08</div> <div>Psychiatrist and RN ok; TRS-day 5; SW-day 2</div> </div> </div>	<p>individualize.</p> <p>Add back psychotropic medication to the Physician Admission Assessment and Certification.</p>
2.	be led by a treating psychiatrist who, at a minimum, shall:		Observations of two Treatment Team meetings.	
a.	assume primary responsibility for the individual's treatment;	SubC (2)		
b.	require that each member of the team participates appropriately in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments	SubC (1)		
c.	require that the treatment team functions in an interdisciplinary fashion; and	SigC		Training and supervision.
d.	require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews occur in a timely fashion; and	SubC (2)		
3.	have its composition dictated by the individual's particular needs, strengths, and preferences, but	SusC		

	shall consist of a stable core of members, including the individual, the treating psychiatrist, the nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the individual's family, guardian, advocates, and the pharmacist and other clinical staff;																			
4.	complete training on the development and implementation of interdisciplinary treatment plans to the point that integrated treatment plans meet the requirements of section IV.B., infra; and	SigC	Observation of two Treatment Team meetings and review of CITP’s provided in binder and as found in charts indicate further work required, especially in writing STG’s in observable, measurable terms and in writing specific interventions.	Consider education process whereby Medical Director or DON meets with Treatment Team to critique CITP process at the time of the CITP.																
5.	meet every 30 days, and more frequently as clinically indicated.	SusC																		
B.	Integrated Treatment Plans  By 24 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols regarding the development of treatment plans consistent with generally accepted professional standards of care, to provide that:																			
1.	where possible, individuals have substantive, identifiable input into their treatment plans;	PC	Patient participation at CITP  <table><tr><td></td><td>Yes</td><td>No</td><td>Unclear</td></tr><tr><td>B-1</td><td>4</td><td>10</td><td>1</td></tr><tr><td>BR</td><td>6</td><td>3</td><td>2</td></tr><tr><td>B-2</td><td>1</td><td>10</td><td>0</td></tr></table>		Yes	No	Unclear	B-1	4	10	1	BR	6	3	2	B-2	1	10	0	PI project or some other methodology to address lack of participation by patients.
	Yes	No		Unclear																
B-1	4	10		1																
BR	6	3	2																	
B-2	1	10	0																	

2.	treatment planning provides timely attention to the needs of each individual, in particular:		Initial Treatment Plans (ITP) is only 2 weeks old.	
a.	initial treatment plans are completed within 24 hours of admission;	SigC		Monitor/audit ITP process and product.
b.	master treatment plans are completed within seven days of admission; and	SusC		
c.	treatment plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter;	SusC		
3.	individuals are informed of the purposes and side effects of medication;	SigC	<p>██████: one word on order sheet, e.g., “psychosis”, “mood” – no evidence discussed anything with the patient. LOS = 1 day.</p> <p>██████: no evidence discussed anything about meds with patient. No rationale for meds on admission, not even one word. No rationale on Comprehensive Physician Progress Note (CPPN)</p> <p>██████: only rationale is for STAT or PRN meds anywhere. No evidence discussed meds with patient.</p> <p>██████: no rationale for meds, not even on order sheet. No evidence of informed consent. Rationale for polypharm: “started as outpatient years ago and has been helpful to him” (?)</p> <p>██████: special order sheet does <u>not</u> have rationale.</p> <p>██████: does note side effects discussed with patient (checked off per line)</p> <p>██████: no informed consent</p> <p>██████: no rationale. No informed consent.</p> <p>██████: no informed consent.</p>	Special order sheets need to be filled in completely after doing required tasks.

4.	each treatment plan specifically identifies the therapeutic means by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented, consistent with generally accepted professional standards of care; and	SigC	<p>CITP have so far not</p> <ul style="list-style-type: none"> <li>• eliminated job descriptions</li> <li>• specified group intervention for specific STG</li> <li>• written interventions in language that directs what a staff person will actually do.</li> </ul> <p>See D.4 below.</p>	Particular attention still needs to be paid to group interventions meeting this criteria.
5.	treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs.	SubC	Daily rounds address this. Observed rounds were quite well done. Weekly Comprehensive Physician Progress Note (CPPN) provides structure to accomplish this. Review of medical records indicates execution needs improvement.	Continue to improve documentation on CPPN's.
C.	By 30 months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is based on a comprehensive case formulation for each individual that emanates from an integration of the discipline-specific assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:			
1.	be derived from analyses of the information gathered from discipline-specific assessments, including diagnosis and differential diagnosis;	SigC		
2.	include a review of pertinent history, predisposing, precipitating, and perpetuating factors, present status, and previous treatment history;	PC	<p>Formulations:</p> <p><u>Nursing</u></p> <p>Collection of facts, but RN does not bring these facts into any "assessment" (see examples provided in notebook #1)</p>	Mostly missing some of these key elements. Conduct qualitative audits and provide further training by Medical Director, DON

			<u>Social Work</u> Case formulation is not one; is short restatement of data	and Director of SW depending on outcomes for each IDT.
3.	consider biochemical and psychosocial factors for each category in Section IV.C.2., supra;	PC	██████████ (closer); ██████████ <u>Psychiatrist (CITP)</u>	
4.	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment interventions;	PC	Reader's Digest version of chart ██ Formulations are not written per Treatment Planning Policy, B31, sec. B.2., 8/11/08	
5.	enable the treatment team to reach sound determinations about each individual's treatment and habilitation needs; and	PC		
6.	make preliminary determinations as to the least restrictive setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	SubC	Observation of two Treatment Team meetings and review of CITP's in binder and in medical records indicates teams have improved in specifically examining impediments to discharge and have tentatively begun to focus treatment on these.	Continue training on differentiating problems that are barriers to discharge and problems that are not prioritizations for barriers to discharge.
D.	By 30 months from the Effective Date hereof, VSH shall use these policies and/or protocols to provide that treatment planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), and that it provides an opportunity to improve each individual's health and well being, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:			
1.	develop and prioritize reasonable and attainable goals/objectives (i.e., relevant to each individual's	SusC		

	level of functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not to be addressed, provide a rationale for not addressing the need;			
2.	provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);	SusC  SubC		Treatment goals remain far advanced compared to skills goals, but nascent improvement in skills goals evident. Presence of Therapeutic and Recreation staff at CITP starting to improve this.
3.	write the objectives in behavioral and measurable terms;	PC	CTP  STG's are not measurable <ul style="list-style-type: none"> <li>• "Treatment Team will help [REDACTED] minimize her thought disorder so she is able to return home in a timely fashion" [REDACTED]</li> <li>• "Social Worker will work with [REDACTED] to..." [REDACTED] [REDACTED] will be able to acknowledge..."</li> <li>• [REDACTED] will understand the importance..."</li> <li>• "[REDACTED] will report that he feels less angry and that he is better able to make good choices within one month" [REDACTED] [REDACTED] will learn two new skills for avoiding substance abuse" [REDACTED]</li> <li>• "Expressing a level of comfort with the idea of living outside" [REDACTED]</li> </ul>	

			<ul style="list-style-type: none"> <li>• “█████ will express an understanding of the steps to move through the legal system” █████</li> <li>• “█████ will remain organized until discharge” █████</li> <li>• “█████ will learn or practice skills for avoiding alcohol use” █████</li> <li>• “█████ will discuss harm reduction around substance use” █████</li> </ul>	
4.	provide that there are interventions that relate to each objective, specifying who will do what and within what time frame, to assist the individual to meet his/her goals as specified in the objective;	PC	<p>Interventions</p> <ul style="list-style-type: none"> <li>❖ Still job descriptions <ul style="list-style-type: none"> <li>• “Nursing staff will offer medication daily” █████</li> <li>• “Social worker will contact the family” █████</li> <li>• “Social worker will facilitate contact with case manager in order to facilitate transition into the community █████</li> <li>• “Social worker will provide updates to guardian” █████</li> <li>• “Dr. M. will meet with Mr. █████ to prescribe medication and assess for benefits and side effects” █████</li> <li>• “TRS will provide groups and activities related to emotional management █████</li> </ul> </li> <li>❖ Unclear who does intervention <ul style="list-style-type: none"> <li>• “Stress important (sic) of social supports...” █████</li> </ul> </li> <li>❖ Unclear exactly what intervention is <ul style="list-style-type: none"> <li>• “Nursing will facilitate attendance at groups...” █████</li> </ul> </li> </ul>	
5.	design a program of interventions throughout the	SigC	Review of records, observation of IDT meetings,	Treatment Mall shows

	individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation per week; and		<p>observation of rounds, discussions with unit staff, and interviews of VSH leadership show this is in its early stages.</p> <p>Mean time available to patients including all groups=16.2 hours.</p> <p>Tour – 10:15 a.m.: <u>Brooks Rehab</u></p> <p>9 patients to Mall; 2 patients per plans on unit</p> <p>1 RN – always on unit; 2 Techs (doing 1:1)</p> <p><u>Brooks 1</u></p> <p>10 patients on unit, 6 on Mall (more than usual)</p> <p>2 restricted; 8 refused</p> <p>Current events on unit</p> <p>3 participated</p> <p>Music group</p> <p>2 participants max (total 3 patients in dayroom); bedrooms open, 7 patients in their rooms. Announce group starting over loudspeaker. One patient on 2:1 (he was sleeping)</p> <p>1 RN, 1 LPN, 6 PT: on unit now</p> <p>1 RN, 1 PT: Mall</p> <p>1 PT on break</p> <p>Groups <u>not</u> posted anywhere patients can see; no printed schedule at all. Oral Morning Schedule: 9:00 a.m.: current events (30 minutes). 30 minutes yard (depends on staff). 15 groups maximum per week at 30 minutes per group.</p> <p>10:30 a.m. <u>Brooks 2</u></p> <p>11 patients – 1 staff held, 10 refused; 9 patients on mall (1 returned at 10:40)</p> <p>3 RN, 4 PT on unit</p> <p>1 RN, 1 LPN, 2 PT at Mall</p> <p>Why 4 RN's + 1 LPN?</p> <p>9:00 a.m. Arts &amp; Crafts</p> <p>4 participated</p> <p>2<sup>nd</sup> group – none as of 10:35 a.m. “Extended</p>	major improvements. Provide results of outcome data, i.e., hours of active treatment for each patient in addition to hours offered.
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			coffee hour.” Supposed to be Current Events. “Theoretically” 15 groups/week; 1 led by RN; 1 led by LPN; 3 by PT; 10 PSR staff. Of these, 13 are named, 2 depend on which staff is on. Patients “encouraged to leave BR.” Once patient out, BR door is locked: 9-11 a.m., 1-3 p.m.	
6.	provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through VSH for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.	SigC	Review of significant number of group progress notes.	Improvement, but still major disconnect between Treatment Teams and PSR programs. This is being actively addressed.
E.	By 30 months from the Effective Date hereof, VSH shall revise treatment plans, as appropriate, to provide that planning is outcome driven and based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified treatment objectives, consistent with generally accepted professional standards of care. Specifically, the treatment team shall:			
1.	revise the objectives, as appropriate, to reflect the individual's changing needs;	SigC	██████████ STG’s met, but no new ones written so have problem, LTG, and interventions, but no STG’s ██████████	Not occurring more often, and hard to advance until objectives themselves better written
2.	monitor, at least monthly, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;	SigC	<ul style="list-style-type: none"> <li>- STG’s met, no replacements, problem still active (?) ██████████</li> <li>- Due 9/14/08, discharged 10/2/08, not done ██████████</li> </ul>	
3.	review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's	SigC	If this is occurring, I did not see evidence in the medical record. Is happening at Rounds, but not reflected in medical record or at next TPR.	Did VSH decide against a CITP Addendum process and form? If so, what is the

	functional status or risk factors;			approach?
4.	provide that the review process includes an assessment of progress related to discharge; and	SubC		Much improvement, but still hampered by inadequate STG's. SW providing better data and follow-up.
5.	base progress reviews and revision recommendations on data collected as specified in the treatment plan.	SigC		Group notes show continued improvement, but not there yet. Psychology much improved.  Psychiatry continues improvement, nursing lagging.  Increase or target training of nursing staff.
<b>V.</b>	<b>MENTAL HEALTH ASSESSMENTS</b>  By 24 months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to VSH, an assessment of the conditions responsible for the individual's admission, and provide that it is accurate and complete to the degree possible given the obtainable information at the time of admission. To the degree possible given the obtainable information, the individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the patient's condition, and, when			



	necessary, for revising assessments and treatment plans in accordance with new information that comes to light. Thereafter, each individual shall receive a reassessment whenever there has been a significant change in the individual's status, a lack of expected improvement resulting from treatment clinically indicated, or six months since the previous reassessment.			
A.	Psychiatric Assessments and Diagnoses			
1.	By 24 months from the Effective Date hereof, VSH shall use the diagnostic protocols in the most current Diagnostics and Statistics Manual ("DSM") for reaching the most accurate psychiatric diagnoses.	SusC		
2.	By 24 months from the Effective Date hereof, VSH shall ensure that all psychiatric assessments are consistent with VSH's standard diagnostic protocols.	SusC		
3.	By 24 months from the Effective Date hereof, VSH shall ensure that, within 24 hours of an individual's admission to VSH, the individual receives an initial psychiatric assessment, consistent with VSH's protocols.	SusC	Recent modification to practice.  Integrated Admission Assessment & Physician Certification  <div style="display: flex; align-items: center;"> <div style="background-color: black; width: 30px; height: 100px; margin-right: 10px;"></div> <div> <div>9/18/08      MD + RN well done</div> <div>9/30/08      OK</div> <div>10/1/08      OK</div> <div>10/2/08      OK</div> <div>9/19/08      OK</div> </div> </div>	
4.	By 24 months from the Effective Date hereof, VSH shall ensure that:			

a.	clinically justifiable, current assessments and diagnoses are provided for each individual;	SusC		
b.	the documented justification of the diagnoses are in accord with the criteria contained in the most current DSM;	SusC		
c.	differential diagnoses, "rule out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed, through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	SusC	Instances of diagnostic evolution from admission to CITP which are quite good. Again, identified through medical record reviews.	
d.	each individual's psychiatric assessments, diagnoses, and medications are clinically justified consistent with generally accepted professional standards of care.	SigC	<p>Psychotic symptoms section often skipped (perhaps since it requires prose).</p> <p>Physical Exam section of psychiatrist's assessment often skipped.</p> <p>Mental Status Exams are too generic. Medications are not yet adequately justified in the medical record.</p>	<p>MD must provide rationale for each medication, and when more than one medication in a class, for the combination of medications.</p> <p>CPPN is good tool, now needs to be more effectively used.</p> <p>There must be an updated assessment by Attending Psychiatrist after Admitting Physician's Assessment. VSH can choose how it will do this. VSH previously agreed to do this.</p>
5.	By 18 months from the Effective Date hereof, VSH shall develop protocols consistent with generally accepted professional standards of care	SusC		

	to ensure an ongoing and timely reassessment of the psychiatric causes of the individual's continued hospitalization.																															
B.	Psychological Assessments	(Note that this section is marked as "A." in the settlement agreement)																														
1.	By 30 months from the Effective Date hereof, VSH shall ensure that patients referred by the treating psychiatrist for psychological assessment receive that assessment, consistent with generally accepted professional standards of care, in a timely manner. These assessments may include diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), rehabilitation and habilitation interventions, behavioral assessments (including functional analysis of behavior in all settings), and personality assessments.	SubC	<p>Psychological assessments reviewed and they were well done. Process put in place to insure psychologist attends CITP to present results.</p> <p>Psychol Service Consult Form &amp; Psychol Evaluation</p> <table><tr><td></td><td>7/2/08</td><td>7/2 to 7/7</td><td>no date</td></tr><tr><td></td><td>?</td><td>3/28 to 4/1</td><td>no date</td></tr><tr><td></td><td>?</td><td>6/2 to 6/3</td><td>no date</td></tr><tr><td></td><td>?</td><td>3/26 to 3/27</td><td>no date</td></tr><tr><td></td><td>?</td><td>3/5</td><td>no date</td></tr><tr><td></td><td>?</td><td>3/19 to 3/20</td><td>no date</td></tr><tr><td></td><td>6/23/08</td><td>6/25 to 6/26</td><td>no date</td></tr></table>		7/2/08	7/2 to 7/7	no date		?	3/28 to 4/1	no date		?	6/2 to 6/3	no date		?	3/26 to 3/27	no date		?	3/5	no date		?	3/19 to 3/20	no date		6/23/08	6/25 to 6/26	no date	<p>Psychology Assessments need to be dated as to (1) date of referral and (2) date assessment completed.</p> <p>Either psychologist or psychiatrist should do MMSE on persons with cognitive impairments.</p>
	7/2/08	7/2 to 7/7	no date																													
	?	3/28 to 4/1	no date																													
	?	6/2 to 6/3	no date																													
	?	3/26 to 3/27	no date																													
	?	3/5	no date																													
	?	3/19 to 3/20	no date																													
	6/23/08	6/25 to 6/26	no date																													
2.	By 30 months from the Effective Date hereof, all psychological assessments, consistent with generally accepted professional standards of care, shall:																															
a.	expressly state the purpose(s) for which they are performed;	SubC		See B.1.																												

b.	be based on current, accurate, and complete data;	SubC		See B.1.
c.	include an accurate, complete, and up to date summary of the individual's relevant, clinical, and functional history and response to previous treatment;	SubC		See B.1.
d.	where relevant to the consultation, include sufficient elements of behavioral assessments to determine whether behavioral supports or interventions are warranted or whether a comprehensive applied behavioral analysis and plan are required;	SubC		See B.1.
e.	include determinations specifically addressing the purpose(s) of the assessment;	SubC		See B.1.
f.	include a summary of the empirical basis for all conclusions, where possible; and	SubC		See B.1.
g.	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records, or re evaluations that should be undertaken in endeavoring to resolve such issues.	SigC		This still needs work. See assessments listed in B.1. Requires greater specification.
3.	By 30 months from the Effective Date hereof, previously completed psychological assessments of individuals currently at VSH shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in Section V.B., supra. By 30 months from the Effective Date hereof, appropriate psychological assessments shall be	SubC		See B.1.

	provided in a timely manner, whenever clinically determined by the team, consistent with generally accepted professional standards of care. These may include whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment or therapeutic programming. The assessment may also be used where clinical information is otherwise insufficient and to address unresolved clinical or diagnostic questions, including "rule out" and deferred diagnoses.			
4.	By 30 months from the Effective Date hereof, when an assessment is completed, VSH shall ensure that treating psychologists communicate and interpret psychological assessment results to the treatment teams, along with the implications of those results for diagnosis and treatment.	SubC	Attending Treatment Teams to Report. At rounds as indicated.	
C.	Rehabilitation Assessments	Note that this section is marked as "B" in the agreement.		
1.	The treating psychiatrist shall determine and document his or her decision, prior to the initial treatment team meeting, whether a comprehensive rehabilitation assessment is required for a patient. When requested by the treating psychiatrist, or otherwise requested by the treatment team or member of the treatment	SubC	Assessments completed on all inpatients. Found in all charts searched.	

	team, VSH shall perform a comprehensive rehabilitation assessment, consistent with generally accepted professional standards of care and the requirements of this Agreement. Any decision not to require a rehabilitation assessment shall be documented in the patient's record and contain a brief description of the reason(s) for the decision.			
2.	By 30 months from the Effective Date hereof, all rehabilitation assessments will be consistent with generally accepted professional standards of care and shall:		Rehabilitation Services Initial & Comprehensive Evaluation  Assessments (Specific strategies to encourage participation...) 	
a.	be accurate and coherent as to the individual's functional abilities;	SubC	Major improvement in form. Major improvement in completing form.	
b.	identify the individual's life skills prior to, and over the course of, the mental illness or disorder;	SubC		
c.	identify the individual's observed and, separately, expressed interests, activities, and functional strengths and weaknesses; and	SubC		
d.	provide specific strategies to engage the individual in appropriate activities that he or she views as personally meaningful and productive.	SigC	Some improvement in content.	Needs a strategy section. Example: how to accommodate hearing loss  Also, diagnoses are <u>not</u> problems; seen on about 50% of reassessments.

3.	By 30 months from the Effective Date hereof, rehabilitation assessments of all individuals currently residing at VSH who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in Section V.C.2., supra.	SusC																																										
D.	<p>Social History Assessments</p> <p>By 18 months from the Effective Date hereof, VSH shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care. This includes identifying factual inconsistencies among sources, resolving or attempting to resolve inconsistencies, explaining the rationale for the resolution offered, and reliably informing the individual's treatment team about the individual's relevant social factors.</p>	SubC	<p>Social Work Assessment + Progress Notes</p> <table> <tr> <th></th><th>Admit</th><th>Assess</th><th>Prog Notes</th><th>DOD</th></tr> <tr> <td>██████████</td><td>9/2</td><td>9/8</td><td>9/12, 9/15</td><td>9/15</td></tr> <tr> <td>██████████</td><td>9/2</td><td>9/5</td><td>9/4</td><td>9/4</td></tr> <tr> <td>██████████</td><td>9/4</td><td>9/12</td><td>X</td><td>9/11</td></tr> <tr> <td>██████████</td><td>9/5</td><td>9/12*</td><td>X</td><td>9/12</td></tr> <tr> <td>██████████</td><td>9/4</td><td>9/16</td><td>9/11, 9/19, 9/26, 10/3</td><td>10/9</td></tr> <tr> <td>██████████</td><td>9/10</td><td>9/15</td><td>9/12, 9/19, 9/26, 10/3</td><td>X</td></tr> <tr> <td>██████████</td><td>9/15</td><td>9/17</td><td>9/17, 9/30</td><td>9/30</td></tr> </table>		Admit	Assess	Prog Notes	DOD	██████████	9/2	9/8	9/12, 9/15	9/15	██████████	9/2	9/5	9/4	9/4	██████████	9/4	9/12	X	9/11	██████████	9/5	9/12*	X	9/12	██████████	9/4	9/16	9/11, 9/19, 9/26, 10/3	10/9	██████████	9/10	9/15	9/12, 9/19, 9/26, 10/3	X	██████████	9/15	9/17	9/17, 9/30	9/30	
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VI.	<p><b>DISCHARGE PLANNING AND COMMUNITY INTEGRATION</b></p> <p>Taking into account the limitations of court imposed confinement, VSH shall pursue actively the appropriate discharge of individuals to the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.</p>																																											

A.	By 30 months from the Effective Date hereof, VSH shall identify at admission and address in treatment planning the particular considerations for each individual bearing on discharge, including:	Note that this section is marked "E" in the agreement.	<div> <div>3/28/37 9/18/08 9/18/08 Discharge summary-good Discharge site = Central Vermont Hospital</div> <div>8/5/85 8/24/08 10/6/08 Discharged to Aunt's house in Middlebury</div> <div>7/31/66 6/18/08 9/27/08 Discharged to Second Spring (came from Second Spring)</div> <div>1/1/54 9/15/08 9/30/08 Discharged per order of court</div> <div>8/26/77 9/14/08 9/19/08 Discharge site = own apartment Aftercare information ok, but no referral for SA services discharge summary</div> <div>8/26/63 6/3/08 9/24/08 Schiz, Paranoid Discharge summary ok; discharged to own home</div> <div>9/21/33 5/9/08 9/26/08 Schizoaffective, Manic Aftercare form ok; discharged to own home</div> <div>Sent from BR because "they could not place him"</div> <div>7/3/89 9/15/08 9/24/08</div> </div>	
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			<p>Disruptive Beh Dis, H/O Conduct Dis, ETOH Dependence  Aftercare form ok; discharge to <u>Motel</u></p> <p>██████████</p> <p>7/3/61 2/19/08 9/25/08  Psychosis NOS  ETOH Dependence  TBI  Discharged to Second Springs</p> <p>██████████</p> <p>7/9/86 4/18/08 10/2/08  Schizophreniform  Possible PTSD  ETOH abuse, Cannabis abuse  PPV→Alternative→Beekman House</p>	
1.	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal goals;	SusC		
2.	the individual's symptoms of mental illness or psychiatric distress;	SusC		
3.	barriers preventing the specific individual from being discharged to a more integrated environment, especially difficulties raised in previously unsuccessful placements, to the extent that they are known; and	SigC	<p>Examined records:</p> <p>██████████ 11 admits/5 in 2008. Recidivism not a problem.</p> <p>██████████: 4 admits/4 in 2008. Recidivism not a problem.</p> <p>██████████: 5 admits/4 in 2008. Recidivism is a problem, but no attempts to understand it.</p> <p>██████████: 10 admits/3 in 2008. Recidivism only viewed in terms of residence.</p> <p>██████████: 17 admits/2 in 2008. "Needs housing and stability in the community to avoid frequent rehospitalization" (only housing considered).</p>	<p>Recidivism beginning to be addressed, but far from consistently done, or when done, paying attention to more than changing discharge site.</p>

4.	the skills necessary to live in a setting in which the individual may be placed.	SigC	Excellent conceptual advancement with “Potential Discharge Destination and Skills Required” drafts 1 and 2.	Implement
B.	By six months from the Effective Date hereof, VSH shall provide the opportunity, beginning at the time of admission and continuously throughout the individual's stay, for the individual to be an active participant in the discharge planning process, as appropriate.	SigC	Findings based on observation of two Treatment Team meetings, review of CITP's, and review of medical records.  – Patient all-too-often not at CITP – Social Worker documents well provision of information, but not clear how patient provides input. – Quite a few patients in a stalemate between where they want to go and where VSH wants them to go.	Work on skills for negotiating with a patient.
C.	By 30 months from the Effective Date hereof, VSH shall ensure that, consistent with generally accepted professional standards of care, each individual has a discharge plan that is a fundamental component of the individual's treatment plan and that includes:			
1.	measurable interventions regarding his or her particular discharge considerations;	PC		Far from consistent at being measurable. Often only says what SW will do.
2.	the persons responsible for accomplishing the interventions; and	SubC	Findings based on observation of two Treatment Team meetings, review of CITP's, and review of medical records.  Current temporary shortage of Social Workers.	SW's notes clear and identified; rest of Treatment Team still remains too absent in the process.  Psychiatrists doing much better.
3.	the time frames for completion of the interventions.	SubC (2)	Generally clear in CITP. Improvement continues to be noted for longer stay patients.	

D.	By 24 months from the Effective Date hereof, when clinically indicated, VSH shall transition individuals into the community consistent with generally accepted professional standards of care. In particular, VSH shall ensure that individuals receive adequate assistance in transitioning prior to discharge.	SubC (2)	<p>Weekly UR meetings:</p> <p>VSH people + Howard staff      Wed  VSH people + Second Spring      Mon  VSH people + HCRS (south of state) every other week  VSH people + DMH, Med Dir, Acute Care Chief, Dir Adult MH Services by telephone conference call (routinely review&gt;120 days) Thurs.</p> <p>Special meetings for</p> <p>DD patients  Dementia  Any case that would span different agencies</p>	
E.	Discharge planning shall not be concluded without the referral of a resident to an appropriate set of supports and services, the conveyance of information necessary for discharge, the acceptance of the resident for the services, and the discharge of the resident.	SubC (2)	<p>Aftercare Referral Form</p> <p>Specific Psychiatric Appointment      12  Without      9  No mental illness      3  Second Spring/Stuart Graves, MD      2  VA      1  Discharged by court      2  Discharged to another state      1  Total      21</p>	
F.	By 30 months from the Effective Date hereof, the State shall develop and implement a quality assurance/improvement system to monitor the discharge process.	Not rated	On hold due to shortage of social workers	
<b>VII.</b>	<b>SPECIFIC TREATMENT SERVICES</b>			
A.	<p>Psychiatric Care</p> <p>By 30 months from the Effective Date hereof, VSH shall provide all of the individuals it serves with adequate and appropriate routine and emergency psychiatric and mental health services</p>	SusC	<p>Review of:</p> <p>List of VSH Active Patients and their Diagnosis  Integrated Admission Assessment and Physician Certification Form, revised September 05, 2008  Admission Assessment Audit Tool and data  MD Initial Assessment Audit Process  MD Weekly Progress note Audit Tool</p>	

	consistent with generally accepted professional standards of care.		VSH Clinical Documentation Guidelines, revised October 1, 2008	
1.	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols regarding the provision of psychiatric care consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address physician practices regarding:			
a.	documentation of psychiatric assessments and ongoing reassessments as per Section V.A., supra;	SusC	<p>VSH has developed and implemented an auditing tool to assess completion of the admission psychiatric assessment. Using the Admission Assessment Audit Tool, VSH reviewed one Admission Assessment and Certification per physician per month. The average sample was approximately 21% of admission assessments during the period of October to August 2008. Initial auditing was conducted by the Quality Manager and the Medical Director reviewed each audited record for final score. The facility's data showed that a target compliance rate of 80% for all the indicators was reached during the period of May to October 2008. VSH did not specify any patterns/trends that emerged from this process.</p> <p>VSH has audited 100% of the admission psychiatric assessments (April to July 2008) and found 100% compliance with the timeliness of the admission psychiatric assessments.</p> <p>Reviewing the charts of 14 individuals [REDACTED] [REDACTED] this monitor found evidence that all assessments were completed within 24 hours of admission and that the new template for the integrated admission assessments was implemented in all cases.</p>	<p>Ensure that the Physician Admission Assessment and Certification includes a plan of care that specifies the pharmacological management, including type of medications, target symptoms, anticipated titration and monitoring strategies and PRN medications with target symptoms/rationale.</p> <p>Ensure that the Physician Admission Assessment and Certification corrects the other deficiencies outlined by this monitor.</p> <p>Continue to monitor the Physician Admission Assessment and Certification based on at least 20% sample</p>

			<p>However, the following deficiencies were identified:</p> <ol style="list-style-type: none"> <li>1. The assessments did not provide specific information regarding a pharmacological plan of care in all the charts reviewed that utilized the facility's most recent format for the assessment. The plan of care that was part of the previous format was adequate as it addressed the type of medication, rationale, titration and monitoring plans.</li> <li>2. In one chart, no neurological consultation was requested when indicated [REDACTED] <ol style="list-style-type: none"> <li>a. In a few charts, no information was provided regarding presence or absence of psychotic symptoms in the target symptoms section [REDACTED]</li> <li>b. In a few charts, the mental status examinations did not include specific information regarding the cognitive examination and/or the status of insight and judgment [REDACTED]</li> <li>c. The physical examination portion of the integrated assessment was not consistently completed.</li> <li>d. VSH has yet to develop a mechanism to ensure that an update of the psychiatric assessments is completed by the seventh hospital day to address historical information that became available after the individual's admission.</li> </ol> </li> </ol> <p>See #2 below for findings regarding the psychiatric reassessments as documented in physician progress notes.</p>	<p>and provide summary data of the results.</p> <p>Ensure that progress notes correct the deficiencies outlined by this monitor.</p> <p>Monitor the physician progress notes documentation based on at least 20% sample and present outline of monitoring indicators, indicator weighing, auditors, methodology of compliance calculation and summary of results.</p> <p>Identify patterns/trends related to admission assessments and progress notes auditing and specify corrective actions that were implemented.</p>
b.	documentation of significant developments in the individual's clinical status and of appropriate psychiatric follow up;	SusC		

c.	timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	SusC		
d.	documentation of analyses of risks and benefits of chosen treatment interventions;	PC	Findings based on observation of two Treatment Team meetings, review of CITP's, and review of medical records and binders.  See IV.B.3.	Still significant deficits: Need to document <ul style="list-style-type: none"> <li>– alternatives considered and shared with patient</li> <li>– risk/benefit analysis for the alternatives</li> <li>– rationale for chosen course of treatment</li> <li>– outcomes</li> <li>– patient is competent to participate in above process or fact that process discussed with alternate decision maker, e.g., guardian</li> </ul>
e.	assessment of, and attention to, high risk behaviors (e.g., assaults, self harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	SubC	Findings based on observation of two Treatment Team meetings, review of CITP's, and review of medical records and binders.  Nursing assessments better, but no actual assessment after data collection. Input from RN into preliminary treatment plan is much better.  Some risks not attended to, e.g., firesetting.	Integration of psychiatric and nursing assessment of risk through plan to address risks needs to be clearer in ITP.  Nursing needs to record assessment based on all the data collected by nursing.
f.	documentation of, and responses to, side effects of prescribed medications; and	SigC	Review of sampling of STAT and NOW orders. STAT or NOW orders rarely have justification for their use. These are often ordered without a face-to-face evaluation by the physician. (same finding as 3/08).	Need to institute mandatory recording of use of STAT meds from preceding week in weekly Attending Psychiatrist note, or

			Nursing inconsistent in documenting results of STAT and NOW orders.	<p>require ordering MD to write contemporaneous progress note.</p> <p>Nursing progress note needs to document side effects of all STAT/NOW medications administered. This should impact psychiatrist's subsequent risk/benefit analysis of the medication prescribed for standing orders.</p>																				
g.	timely review of the use of "pro re nata" or "as needed" ("PRN") medications and adjustment of regular treatment, as indicated, based on such use.	SigC	<p>P/P for orders for PRN's which indicated 7 days maximum was rescinded.</p> <p>PRN orders</p> <table> <tr> <td></td> <td>Antipsychotic</td> <td>Benzo</td> <td>Hypnotic</td> <td>None</td> </tr> <tr> <td>B-1</td> <td>2</td> <td>9</td> <td>0</td> <td>3</td> </tr> <tr> <td>BR</td> <td>3</td> <td>1</td> <td>0</td> <td>8</td> </tr> <tr> <td>B-2</td> <td>8</td> <td>8</td> <td>3</td> <td>7*</td> </tr> </table> <p>* 2 have hydroxyzine for anxiety</p> <p>PRN's: 1) Percocet (Oxycodone) 10mg q 4 foot pain Administered 4x 10/7 2) Diazepam 10mg q 12 agitation Administered 1x 10/7 3) Cogentin 1 q 6 EPS None</p> <p>Standing: Haldol 15mg 4:00 p.m. Percocet usage – 2-4/day, more often 4</p> <p>MD CPPN Comment on Percocet (started on admission)    Comment on Psychotic (mostly duplicative)</p>		Antipsychotic	Benzo	Hypnotic	None	B-1	2	9	0	3	BR	3	1	0	8	B-2	8	8	3	7*	<p>VSH shall</p> <ol style="list-style-type: none"> <li>1. Add prn's to Physician Admission Assessment and Certification (p 12).</li> <li>2. Institute procedure such that Pharmacy will not fill <i>any</i> psychotropic medication order without at least a (perfunctory) rationale on the order sheet, including prn's and STAT/NOW orders.</li> <li>3. Immediate return orders which fail to have rationales to the ordering physician for modification, i.e.,</li> </ol>
	Antipsychotic	Benzo	Hypnotic	None																				
B-1	2	9	0	3																				
BR	3	1	0	8																				
B-2	8	8	3	7*																				

			<p>notes; does comment on SA + benzo)</p> <p>10/6      0      +++  10/3      0      +++  9/26      0      +++  9/16      0      +++  9/9      0      +++  8/19      0      +++  8/12      0      0</p> <p>██████ Quetiapine 50 q 12  documented 10/6  not documented 9/29, 9/22, 9/16</p> <p>██████ Lorazepam, Trazodone  one med doc 10/2, 9/24, 9/16, 9/12 (duplicate  statement about Lorazepam)  Trazodone – no documentation</p> <p>██████ Clonazepam  no documentation last 4 notes-is that because  no use? What about the order itself?</p>	<p>additions of rationale at least.</p> <p>4. Audit physician documentation around prn's, STAT, and NOW orders, with appropriate feedback to physicians.</p>
2.	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols to ensure system wide monitoring of the safety, effectiveness, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and/or protocols shall address:			
a.	monitoring of the use of psychotropic medications to ensure that they are:	<p>SubC for process  PC for outcomes</p>	<p>PRN use remains high without adequate justifications.</p> <p>VSH has a drug interaction procedure through the pharmacy.</p> <p>VSH is in the early stages of proper documentation of the benefits and risks of benzodiazepine use for most patients, and particularly for patients who have documented history of substance use disorders.</p> <p>VSH has implemented a Medication Consultation Form</p>	<p>Refine monitoring/peer review systems to ensure compliance with facility standards.</p> <p>Identify practitioner trends/patterns, integrate data in the current peer review system and institute</p>

		for review by Med Dir:	educational corrective actions, as needed, for prn usage.
		<div style="background-color: black; width: 30px; height: 15px; margin-bottom: 5px;"></div> 8/20/08      dose over max <div style="background-color: black; width: 30px; height: 15px; margin-bottom: 5px;"></div> 8/8/08        dose over max <div style="background-color: black; width: 30px; height: 15px; margin-bottom: 5px;"></div> 8/5/08        dose over max <div style="background-color: black; width: 30px; height: 15px; margin-bottom: 5px;"></div> 7/23/08       dose over max <div style="background-color: black; width: 30px; height: 15px; margin-bottom: 5px;"></div> 7/16/08       polypharm	
		Use of this process, or peer review, should be expanded. VSH has active Pharmacy Intervention process: 9/08                  Total 27  Polypharm     5 Drug-drug interaction   8 Incorrect dosage     3  These are clinically useful and well done.	
		Since the last review, VSH has implemented the new template for documentation of the psychiatric reassessments. This template comports with generally accepted standards as it provides information in the following categories of review:	Other recommendations in this section are now integrated with the recommendations in VII.2.d.
		<ol style="list-style-type: none"> <li>1. Reason for hospitalization/chief complaint</li> <li>2. Interval history</li> <li>3. Current medications, including PRN medications</li> <li>4. Use of restrictive interventions during the interval</li> <li>5. Update on progress regarding social skills training and behavioral interventions, as applicable</li> <li>6. Update of past family/social history information, as applicable</li> <li>7. Mental status examination</li> <li>8. Assessment/Plan</li> <li>9. Risk of Harm</li> <li>10. Analysis of emergency interventions</li> <li>11. Outcome of behavioral plan, update</li> </ol>	

			<p>12. Rationale for polypharmacy  13. Analysis of PRN use  14. Barriers to discharge  15. Estimated discharge date  16. Counseling/education, as needed</p> <p>The review of the charts of 14 patients who have been hospitalized at least for one month [REDACTED]  [REDACTED]  [REDACTED] was completed. The review focused on the implementation of the facility's new template for psychiatric reassessments. found deficiencies in the following areas:</p> <ol style="list-style-type: none"> <li>1. Assessment and documentation of suicidality/homicidality in an individual who was refusing to meet with the psychiatrists but was able to communicate with nursing staff</li> <li>2. Adequate analysis of the risks and benefits of current treatment and attempts to use safer and effective treatment alternatives</li> <li>3. Proactive evaluation of risk factors and timely modification of treatment to minimize the risk of restrictive interventions</li> <li>4. Critical review of the circumstances leading to PRN/Stat medication use and adjustment of regular treatment as a result of this review</li> <li>5. Prescription of PRN medications for generic indications</li> <li>6. Lack of adequate documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the repeated use of PRN medications</li> <li>7. Lack of behavioral guidelines for some individuals who were refractory to current medication trials</li> </ol>	
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			<p>■ Inconsistent documentation of a face-to-face assessment by the psychiatrists within 24 hours of the administration of Stat medications ■</p> <p>VSH no longer provides a time limit on the use of PRN medications. The Pharmacy Department has discontinued the automatic stop order for technical reasons.</p>	
i.	clinically justified;	PC	<p>Antipsychotic medications justified with the most cursory documentation, if at all, remains unchanged.</p> <p>The use of benzodiazepines does not appear to be adequately evaluated and justified. Marginal improvements when being prescribed for persons with substance use disorders.</p> <p>PRN's often not justified. STAT/NOW orders almost never justified.</p>	<p>The use of each medication must be clinically justified in assessments and/or progress notes. One or two word statements on order sheets can be the initial statement, but are not sufficient – no individualization, inadequate justification. Require documentation to progress notes – in addition to order sheet and use as QA indicator.</p>
ii.	prescribed in therapeutic amounts, as dictated by the needs of the individual patient;	SubC	See 2.a above.	<p>Review process established for medication over dose limits.</p> <p>Improve rationale specifically addressing dosages when two meds used within neither near therapeutic limit. Need rationale when standing order + prn order exceed threshold.</p>

iii.	tailored to each individual's clinical needs;	SubC (2)	Only rare cases where medication and diagnosis not readily compatible.  Individuation of justification needs considerable attention.	See recommendations earlier in this section.
iv.	monitored for effectiveness against the objectives of the individual's treatment plan;	SigC	Some improvement, but still inconsistently documented; appears to occur clinically often, but often no way to know. Psychiatric progress notes and other discipline's progress notes should reference specific problem-goal-objective. Need improved STG's on CITP - see Section IV throughout.	
v.	monitored appropriately for side effects; and	SigC	Refusal of assessments, VS, PE, lab remain a problem.  Some improvement with CPPN, but still requires better documentation.	Improve documentation on CPPN.  Develop individualized treatment approach to these refusals. Perhaps PIP to address this facility problem.
vi.	properly documented;	SigC		Need much more effective use of templates, e.g., CPPN. Need qualitative reviews by QM Department.
b.	monitoring of the use of PRN medications to ensure that these medications are clinically justified and administered on a time limited basis;	PC	See 1.g. and 2.a. above.	Revise Policy and Procedure per 1.g.  Training for psychiatrist.  Improve use of CPPN for this purpose.  Monitor outcomes of improved training through qualitative

				reviews.
c.	timely identification, reporting, data analyses, and follow up remedial action regarding adverse drug reactions reporting ("ADR");	SigC	<p>Review of:</p> <p>VSH Pharmacy &amp; Therapeutics (P&amp;T) Committee  Report: ADRs, Marcy – August 16, 2008  VSH ADR Report: Working Copy Review  ADR Investigation by Medical Director  ██████████</p> <p>Outline of ADR Staff training  Clinical Pharmacology: Quick Reference Guide  VSH Nursing Assessment-ADRs Post-test  VSH Drug utilization Evaluation Grid June to September 2008  Examples of ADR reports (Quantros)</p> <p>VSH has implemented its new IT system, QUANTROS in the reporting of ADRs. The system has provided information on the following:</p> <ol style="list-style-type: none"> <li>1. Name and discipline of the person initiating the report See 1.g. and 2.a. above.</li> <li>2. Event specific details, including a narrative factual description of events involving the variance See 1.g. and 2.a. above.</li> <li>3. Identification of the drug(s) given to the patient that are suspected of causing the reaction See 1.g. and 2.a. above.</li> <li>4. The effect and outcome of the ADR See 1.g. and 2.a. above.</li> <li>5. Action(s) taken to address the ADR, including action(s) for future screening See 1.g. and 2.a. above.</li> <li>6. Physician notification See 1.g. and 2.a. above.</li> <li>7. Follow-up investigations by nurse manager See 1.g. and 2.a. above.</li> </ol>	<ol style="list-style-type: none"> <li>1. Increase reporting of ADRs.</li> <li>2. Provide further training to enter information regarding a probability scale for ADRs and information regarding other drugs suspected of causing the ADR.</li> <li>3. Provide data regarding ADRs during the reporting interval to include: <ol style="list-style-type: none"> <li>a) Total number of ADRs</li> <li>b) Number and summary description of ADRs in category F and higher, with specific outcomes to patients in each case</li> <li>c) Classification of all ADRs based on a probability scale</li> <li>d) Any intensive case analysis regarding an ADR</li> </ol> </li> <li>4. Develop and implement a format for an intensive case analysis to ensure that the analysis addresses: <ol style="list-style-type: none"> <li>a) the circumstances of the event, b)</li> </ol> </li> </ol>

			<p>8. Severity of the event See 1.g. and 2.a. above.</p> <p>VSH provided training to its physicians and nursing staff regarding ADR reporting using a computer program named Clinical Pharmacology.</p> <p>During this review period, VSH reported nine ADRs. Only one of these reactions was classified as severe and required intensive case analysis. The reaction involved the possible occurrence of neuroleptic malignant syndrome. VSH did not provide information regarding ADRs based on a probability scale or adequate information regarding other drugs suspected of causing the ADRs.</p> <p>The intensive case analysis that was completed during this review period included adequate review of clinical circumstances. However, VSH has yet to develop a format of the intensive analysis to address preventability of the reaction, contributing factors, conclusions and recommendations for corrective actions, with follow up.</p> <p>The facility has yet to integrate data regarding ADRs in the current system of psychiatric peer review, provide analysis of individual and group practitioner trends and patterns regarding ADRs and institute meaningful corrective and educational activities for performance. In addition, the facility's P &amp; T Committee has yet to review/analyze ADRs derived from the new electronic system to establish trends/patterns requiring corrective actions.</p>	<p>preventability of the reaction, c) contributing factors, d) conclusions and e) recommendations for corrective action, with follow up.</p> <p>5. Integrate data regarding ADRs in the current system of psychiatric peer review.</p> <p>6. Provide analysis of individual and group practitioner trends and patterns regarding ADRs and institute meaningful corrective and educational activities for performance improvement.</p>
d.	drug utilization evaluation ("DUE") in accord with established, up to date medication guidelines;	SigC	<p>Review of: VSH Drug Utilization Evaluation (DUE) Grid.</p> <p>During this review period, VSH has implemented the individualized Clinical Practice Guidelines and used these guidelines as part of the medication order forms to facilitate compliance. The guidelines included adequate monitoring parameters. As</p>	<p>1. Finalize and implement guidelines and DUE instruments to address the following</p> <ul style="list-style-type: none"> <li>a. Benzodiazepine use</li> <li>b. Anticholinergic</li> </ul>

			<p>mentioned in the previous report, the guidelines addressed the use of the following medications: clozapine; new generation antipsychotic medications (other than clozapine); tricyclic antidepressants; monoamine oxidase inhibitors; carbamazepine and oxcarbazepine; lamotrigine; lithium; divalproex; mirtazepine; bupropion; nefazodone and trazodone; venlafaxine and duloxetine; and serotonin-specific reuptake inhibitors.</p> <p>VSH has updated its clozapine guideline and addressed additional side effects, plasma levels and strategies for patients who fail to respond satisfactorily. The facility's guidelines have yet to include indicators regarding the use of PRN/Stat medications, benzodiazepines, anticholinergics and/or management of TD. The current guideline regarding the use of polypharmacy includes information relevant to the use of benzodiazepines and anticholinergics but no specific indicators were included.</p> <p>During this review period, the facility's Medical Director conducted DUEs based on the above guidelines. Reviewing 10 charts for each psychiatrist, the DUEs found compliance with the monitoring indicators in all charts. The data indicate that DUEs were conducted on the use of benzodiazepines and anticholinergic medications but the facility does not have a DUE instrument (medication order form) that outlines the indicators to be used in these DUEs.</p> <p>VSH reported that DUE data have been tracked and trended and that feedback has been provided to practitioners during clinical supervision meetings with the Medical Director.</p>	<p>medication use</p> <p>c. Monitoring and management of tardive dyskinesia</p> <p>d. Expectations regarding use of PRN/Stat medications</p> <p>2. Continue implementation of the DUE system based on the individualized medication guidelines.</p> <p>3. Provide data using the DUE instruments for PRN/Stat medications, benzodiazepines, anticholinergics and new generation antipsychotic medications.</p> <p>4. Ensure integration of DUE data in the current peer review system and utilization of data in performance improvement activities.</p>
e.	documentation, reporting, data analyses, and follow up remedial action regarding actual and	PC	<p>Review of:</p> <p>P&amp;T Committee Medication Variance report,</p>	<p>1. Provide further instruction to clinicians regarding proper</p>

	potential medication variances ("MVR");		<p>August 2008</p> <p>During this review period, VSH has implemented its new IT system (QUANTROS) in reporting medication variances. The system has provided information in the following areas:</p> <ol style="list-style-type: none"> <li>1. Name and discipline of the person initiating the report</li> <li>2. Event specific detail; including a narrative factual description of the events involving the ADR</li> <li>3. Identification of the medication (s) involved</li> <li>4. Evaluation of why the event has occurred and assessment of critical breakdown points</li> <li>5. Review of contributing factors</li> <li>6. Severity of the event</li> </ol> <p>The facility provided training to its physician and nursing staff regarding the use of QUANTROS in reporting medication variances.</p> <p>During this review period, VSH has reported 104 variances. Reviews by this monitor found the following deficiencies:</p> <ol style="list-style-type: none"> <li>1. The facility's data regarding actual vs. potential variances were inaccurate.</li> <li>2. Most of the variances were limited to the following categories: <ol style="list-style-type: none"> <li>a) Transcription variances</li> <li>b) Missed or late doses</li> <li>c) Omitted drugs of laboratory tests</li> <li>d) Some documentation variances</li> </ol> </li> <li>3. No variances were reported in some important categories including, but not limited to prescription, ordering (by pharmacy), dispensing, storage and medication security.</li> <li>4. The facility did not provide adequate information regarding its clinical review process, the basis for determination of critical</li> </ol>	<p>methods of reporting medication variances in all the possible categories of variance and methods for determination of critical breakdown points</p> <ol style="list-style-type: none"> <li>2. Provide data regarding medication variances during the reporting period that include the following: <ol style="list-style-type: none"> <li>a) Total number of actual and potential variances</li> <li>b) Number of variances in each category (prescription, transcription, administration, documentation, monitoring, dispensing, ordering, storage and medication security)</li> <li>c) Number and summary description of variances that were classified as serious (category F and more), with specific outcomes to patients in each case</li> <li>d) An outline of Critical breakdown points</li> <li>e) Any intensive case analysis that involved a</li> </ol> </li> </ol>
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			<p>breakdown points, the full chain of events involved in the occurrence of some variances and physician review and future screening.</p> <p>5. The facility's P &amp; T Committee has yet to review/analyze ADRS derived from the new electronic system to establish trends/patterns requiring corrective actions.</p> <p>None of the variances reported during this review period was classified as severe or met threshold for an intensive case analysis.</p> <p>VSH provided some aggregation and analysis of its data. The facility reported that a performance improvement project was initiated to address documentation in the Medication Administration Record (MAR).</p>	<p>medication variance</p> <p>3. Develop and implement a format for an intensive case analysis to ensure that the analysis addresses:</p> <p>a) the circumstances of the variance, b) preventability of the event, c) contributing factors, d) conclusions and e) recommendations for corrective action, with follow up.</p> <p>4. Integrate data regarding medication variances in current peer review activities.</p> <p>5. Provide analysis of individual and group practitioner trends and patterns regarding MVR and institute meaningful corrective and educational activities for performance improvement.</p>
f.	tracking of individual and group practitioner trends;	PC	Same as above.	
g.	feedback to the practitioner and educational/corrective actions in response to identified trends, when indicated; and		The deficiencies outlined in a through e above preclude meaningful assessment of this requirement at this time.	
h.	use of information derived from ADRs, DUE, MVR, and providing such information to the	PC	Same as above.	

	Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees.			
3.	By 30 months from the Effective Date hereof, VSH shall ensure that all physicians and clinicians are performing in a manner consistent with generally accepted professional standards of care, to include appropriate medication management, treatment team functioning, and the integration of behavioral and pharmacological treatments.	SubC(1)	Efforts hampered by 1) less than always appropriate admissions:  Primary Discharge Diagnosis by Patient * (3/1/08 through 8/12/08)  Schizophrenia/Schizoaffective/Psychosis NOS 44 Delusional Disorder 1 Bipolar 20 Major Depression 7 Other Mood Disorder 8 PTSD** 9 Other Anxiety Disorder 1 Alcohol/Substance 3 Impulse Control 2 Adjustment 9 Cognitive Disorder/Delirium/Dementia 4 Personality Dis Borderline 1 Other 0  * 4 patients also have MR diagnosis  ** 6 of the 9 with PTSD also have Borderline ** Personality Disorder and by 2) Vermont law, i.e., Act 114.	Improvement continues. Specifics for improvement documented through report. That conditions outside VSH significantly impair physicians' ability to act according to generally accepted standards of practice is itself outside the scope of this report but does impact upon VSH's ability to come into compliance.
4.	By 30 months from the Effective Date hereof, VSH shall review and ensure the appropriateness of the medication treatment, consistent with generally accepted professional standards of care.	SubC(1)		See all of Section VIIA.
5.	By 30 months from the Effective Date hereof, VSH shall ensure that individuals are screened and evaluated for substance abuse. For those individuals identified with a substance abuse disorder, VSH shall provide them with	SigC	SA Assessment  ██████: Ok, but not in any SA groups or groups suggested by assessment  ██████: No SA assessment; 5 day LOS; dx's includes Cannabis Abuse or Dep	Early efforts are good. Still not at generally accepted standard of care. Require: <ul style="list-style-type: none"><li>improved education of IDT as to when to seek</li></ul>

	appropriate inpatient services consistent with their need for treatment.		<p>██████: No SA assessment; 9 day LOS; dx's includes ETOH Dependence (██████ y.o.)</p> <p>██████: No SA assessment; psychiatrist says on admit needs one; dangerous (firesetting) while drunk-multiple</p> <p>██████: No referral for SA at/after admit; dx- ETOH abuse</p> <p>██████: Referral for dx = "Polysub abuse"</p> <p>██████: No SA assessment; ETOH/Cannabis abuse</p> <p>██████: No SA assessment; ETOH/Cannabis dependence; patient refused to provide info on admission</p>	<p>consult</p> <ul style="list-style-type: none"> <li>• greater number of SA groups, with greater range of offerings</li> <li>• improved focus on dual disorders</li> </ul>
B.	<p>Psychological Care</p> <p>By 30 months from the Effective Date hereof, VSH shall provide adequate and appropriate psychological supports and services, consistent with generally accepted professional standards of care, to individuals who require such services.</p>			
1.	By 30 months from the Effective Date hereof, VSH shall ensure, consistent with generally accepted professional standards of care, adequate capacity to meet the needs of patients in the following areas of psychological services:			
a.	behavioral treatment;	SigC	<p>Review of:</p> <p>Psychology Service Interim Report: Summary of Changes since March 2008</p> <p>Psychological Service Consultation Form</p> <p>Functional Analysis of Behavior ██████████</p> <p>██████████</p> <p>Behavioral/Case Consultation ██████████</p> <p>██████████</p>	

			<p>Updates to Behavioral/Case Consultations</p> <p>████████████████████</p> <p>Positive Behavioral Supports Policy, February 11, 2008</p> <p>VSH Levels of Autonomy and Supervision Policy, revised September 17, 2008</p> <p>VSH Levels of Observation policy, revised, September 02, 2008</p> <p>In June 2008, the Psychology Service Director ██████████ retired, psychologist ██████████ became the interim Psychology Service director and contract Psychologist ██████████. increased her time to three days per week. Since that time, ██████████ have provided all psychology services at the facility.</p> <p>VSH has implemented its policy and procedure regarding PBS (finalized in February 2008). To support implementation of this policy, the psychology service has provided the following activities:</p> <ol style="list-style-type: none"> <li>1. Psychologist's participation in weekly team rounds</li> <li>2. Behaviorally informed training of clinical staff at the facility, including overview of behavior support services and orientation for all new employees</li> <li>3. Consultations with treatment teams, including patients to develop pro-social and adaptive behaviors and to minimize maladaptive behaviors</li> <li>4. Assistance to the treatment teams in the identification of patients exhibiting high risk behaviors and developing and implementing behavioral interventions to address these behaviors</li> </ol> <p>Since the last review, VSH has completed three</p>	<ol style="list-style-type: none"> <li>1. Continue training of clinicians on the principles and practice the PBS model and provide specific information regarding training provided to staff across shifts and settings during the review period.</li> <li>2. Increase the use of functional analysis as the basis for behavioral interventions and provide information on all analyses completed during this review period.</li> <li>3. Provide information on all consultations, including updates that were completed during the review period.</li> <li>4. Develop Operational criteria for referral to the behavioral consultation</li> </ol>
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			<p>additional behavioral consultations based on the current triggers/thresholds [REDACTED]</p> <p>[REDACTED] In addition, the facility has developed functional analyses for two patients [REDACTED]</p> <p>[REDACTED] The most recent analysis included the following methods:</p> <ol style="list-style-type: none"> <li>Direct observation of patients and staff</li> <li>Chart reviews</li> <li>Patient interviews</li> <li>Staff interviews</li> <li>Objective measures (the FAST)</li> <li>Identification of important functional goals of the patient</li> <li>Identification of replacement behaviors to be utilized as treatment goals</li> </ol> <p>In addition, the facility has updated the functional analyses/behavioral consultations of the above-mentioned five individuals [REDACTED]</p> <p>[REDACTED]</p> <p>Review of the most recent functional analysis (# [REDACTED]) and updates of the analyses and consultations during the past six months showed that the facility has made progress since the last review. The following are examples of the areas of progress:</p> <ol style="list-style-type: none"> <li>The functional analysis provided adequate framework for understanding the motivations and the factors maintaining the maladaptive behaviors.</li> <li>Interventions were focused on reasonably well defined behaviors. This was evidenced by description of problematic behaviors in the Consultation form and the identification of specific marker variables as well as desired outcomes in the monitoring of behavior intervention effectiveness.</li> <li>Behavioral consultations included</li> </ol>	<p>services.</p> <ol style="list-style-type: none"> <li>Ensure that behavioral interventions are provided to all individuals who meet referral criteria.</li> <li>Ensure that the behavioral interventions are specified in the objectives and interventions sections of the treatment plans.</li> <li>Ensure that the psychiatric progress notes reflect adequate integration of behavioral and pharmacological interventions.</li> </ol>
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			<p>identification of most significant maladaptive behaviors to address first, phasing in other, less significant behaviors as necessary. Significance was determined on the basis of safety/risk behaviors.</p> <p>4. For behavioral interventions that were developed on the basis of functional analysis, direct observation of behaviors was included as a specific outcome measurement. The observations and recording of behavioral data were provided by unit staff directly. These data were used to monitor interventions for effectiveness and to make changes as indicated by the data.</p> <p>5. Precursor behaviors were assessed during functional assessment/behavioral consultations and addressed in interventions as appropriate.</p> <p>6. Potential reinforcers were identified during staff interviews and chart review. Patient interviews focused on motivations, hospitalization and life goals, personal preferences and quality of life issues in addition to simple reinforcers. These were used to tailor behavioral interventions.</p> <p>7. Adaptive replacement behaviors were identified through an understanding of the function of the maladaptive behavior. Interventions to promote these behaviors included specific skills training or involvement in individual or group therapies designed to assist in the development of specific skills to replace maladaptive behaviors.</p> <p>8. Desired outcomes were identified and reflected improvement in quality of life measures (e.g., ability to engage in desired behaviors, freedom from restrictive procedures, trips outside the hospital, transition to less restrictive environments).</p>	
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			<p>9. Psychologists have provided staff training across units and settings (e.g., canteen, treatment mall, on all relevant shifts) to assure fidelity to behavioral interventions. This activity is documented in the bi-weekly behavioral consultation follow-up form.</p> <p>10. Progress on behavioral goals was monitored through data collection and/or discussion with unit staff, and was documented every two weeks on the Behavior Consultation Follow-up form. This allowed for evaluation of the effectiveness of the interventions.</p> <p>Because of the time intensive assessment required for completion of functional analysis, the facility has reserved these analyses for patient who did not respond to less intensive evaluation/interventions that were completed in the context of the consultation process.</p> <p>The facility has yet to make progress in ensuring that more analyses and interventions are developed for all patients in need, that the behavioral interventions are specified in the objectives and interventions sections of the treatment plans and that behavioral interventions are well integrated with pharmacological interventions.</p>													
b.	group therapy;	SubC(1)	<p>Efforts to increase and improve group offerings is reaping benefits. Work on group interventions based on patients’ clinical needs and less on preference has progressed well.</p> <p>Vast improvement with newly created mall, but still</p> <table><tr><th colspan="2">Groups Cancelled Due to Staff Shortage</th></tr><tr><th>Week of</th><th>No. Cancelled</th></tr><tr><td>8/11/08</td><td>1</td></tr><tr><td>8/18</td><td>2</td></tr><tr><td>8/28</td><td>3</td></tr><tr><td>9/15</td><td>2</td></tr></table>	Groups Cancelled Due to Staff Shortage		Week of	No. Cancelled	8/11/08	1	8/18	2	8/28	3	9/15	2	<p>Congratulations on progress with Treatment Mall.</p> <p>Work on better integration of CITP and groups.</p>
Groups Cancelled Due to Staff Shortage																
Week of	No. Cancelled															
8/11/08	1															
8/18	2															
8/28	3															
9/15	2															

			9/22 3 9/29 3  Satisfaction is high with groups based on survey results													
c.	psychological testing;	SubC(1)	Major improvements by the team of Laura Gibson, Ph.D. and Elliot Benay, MA.	See Section VB.												
d.	family therapy; and	SigC	Family participation in CITP is close to nil. <table><tr><td></td><td>Family Member</td><td>No. of CITP's</td></tr><tr><td>B-2</td><td>0</td><td>11</td></tr><tr><td>BR</td><td>0</td><td>11</td></tr><tr><td>B-1</td><td>0</td><td>15</td></tr></table> Major step forward with the Interdisciplinary Family Intervention form (IFIF).		Family Member	No. of CITP's	B-2	0	11	BR	0	11	B-1	0	15	Offer Family Therapy at times families more likely to be able to participate.  Increase family participation in CITP development, such as use of participation by phone if onsite participation not feasible.  Put IFIF in regular use.
	Family Member	No. of CITP's														
B-2	0	11														
BR	0	11														
B-1	0	15														
e.	individual therapy.	SubC(1)	Formal referral process for individual therapy to be provided by psychology.  Tracking of individual therapy provided by psychology now in place.  Individual therapy notes by psychology in place.  Psychology Service Individual Psychotherapy Log  2007 total of 1 case 2008 Jan-April 0 cases initiated May 1: case initiated June 5: case initiated July 3: case initiated August 2: case initiated September 2: case initiated Individual Therapy Progress Notes 9/19/08 five 15' sessions													

			9/26/08 four 15' sessions 9/11/08 two 35' sessions 9/27/08 one 40' session; two 10' sessions 10/2/08 one 35' session; one 15' session	
2.	By 30 months from the Effective Date hereof, VSH shall provide adequate clinical oversight to therapy groups to ensure that individuals are assigned to groups that are appropriate to their individual needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed consistent with generally accepted professional standards of care.	SigC	Group referral process by IDT Team needs work.  Groups as interventions on CITP's most commonly read: "TRS will provide treatment mall programming." "TRS will provide on unit groups."  SA needs further work, see A.5. above.	Steps continue to progress. Significant improvement, but still early in the process. Current course of action should continue to evolve towards full integration of Treatment Mall and Treatment Teams.
3.	By 30 months from the Effective Date hereof, VSH shall provide adequate active psychosocial rehabilitation, consistent with generally accepted professional standards of care, that:	On Treatment Mall, SubC(1)  On Units, PC		Attend to patients' needs on the unit while developing Mall.
a.	is based on individualized assessment of patients' needs and is directed toward increasing patient ability to engage in more independent life functions;	SigC	PSR Assessment better.  Unit/Team and TRC staff interacting more (TRS staff at Treatment Teams) but still need to develop IDT Team role of referring patient to specific groups for specific objectives.	Attention to disconnect between CITP and PSR.
b.	addresses those needs in a manner building on the individual's strengths, preferences, and interests;	SigC	Improvement. Movement of focus on patient's preferences to greater attention to needs.	
c.	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	SigC	Some improvement in SA and recidivism; both need considerably more attention.  Little to no attention to individual's vulnerabilities. This should be in the formulations.	Improve formulations.

d.	is provided in a manner consistent with each individual's cognitive strengths and limitations;	SigC	Evidence this is beginning to be addressed – see treatment approach for [REDACTED].	Integrate psychology testing results into CITP.  IDT should specify learning difficulties on CITP.  Track patients with MR diagnosis.
e.	is provided in a manner that is clinically appropriate as determined by the treatment team;	PC	Still inadequate communication between IDT team and PSR group leaders. Presence of TRS staff at Team Meetings is improving this. Not clear how mall skills are worked with by second shift.	
f.	routinely takes place as scheduled, for those interventions that are scheduled;	On Treatment Mall, SubC(1) On Units, PC		
g.	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life;	SubC(1)	More Active RX: Evening Group (in basement area) 6:00-7:00 p.m.  Mon – Animal Assisted Rx Tues. – AA group Wed. – Wellness & Recovery Thurs. – Open Group, changes week-to-week  Weekend Group (Sunday)  Not set curriculum  1) Anger Management, 2) Coping with Stress, 3) Symptom Management, 4) Leisure Skills	Expand so all patients can participate.
h.	prescribes a role for the staff on the living units; and	PC	Discussions with first and second shift staff.  First shift staff are doing better comprehending carryover from Mall to Unit. Second shift staff don't seem involved yet.	Need specific training and supervision for all direct care staff with greatest focus on 2 <sup>nd</sup> shift.

Fifth Compliance Report

i.	is documented in the individual's treatment plan.	SigC	Starting to be tied to STG's.	Considerable focus needed here.
4.	By 30 months from the Effective Date hereof, VSH shall ensure that:	SigC	Same as in VII.B.1.a	Same as in VII.B.1.a
a.	behavioral interventions are based on positive reinforcements rather than the use of aversive contingencies, to the extent possible;	SigC	Same as in VII.B.1.a	Same as in VII.B.1.a
b.	programs are consistent for each patient within all settings at VSH;	SigC	Same as in VII.B.1.a	Same as in VII.B.1.a
c.	triggers for considering instituting individualized behavior treatment support plans are specified and utilized, and that these triggers include excessive use of seclusion, restraint, and emergency involuntary medication;	SigC	Same as in VII.B.1.a	Same as in VII.B.1.a
d.	psychotherapy, whenever prescribed, is goal directed, individualized, and informed by a knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to psychotherapy;	SubC(1)		Documentation remarkably improved.
e.	psychosocial, rehabilitative, and behavioral interventions are monitored and revised as appropriate in light of significant developments, and the individual's progress, or the lack thereof;	SigC	Not much change in IDT's demonstrated ability.	This process is severely hampered by fact that STG's are not measurable.
f.	clinically relevant information remains readily accessible; and	SigC	Group notes getting done, but do not address STG.	
g.	all staff who have a role in implementing	SigC	Same as in VII.B.1.a	Same as in VII.B.1.a

	individual behavioral programs have received competency based training on implementing the specific behavioral programs for which they are responsible, and quality assurance measures are in place for monitoring behavioral treatment interventions.			
C.	<p>Pharmacy Services</p> <p>By 30 months from the Effective Date hereof, VSH shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols that require:</p>			
1.	pharmacists to complete reviews of each individual's medication regimen regularly, on at least a monthly basis, and, as appropriate, make recommendations to treatment teams about possible drug to drug interactions, side effects, medication changes, and needs for laboratory work and testing; and	SigC	Review of patients' medication does not occur at least monthly. Pharmacy reports to psychiatrists well done.	Arguably a patients' medication is automatically reviewed whenever a new medication is ordered. The question is what is the review process if no medication changes in a month?
2.	physicians to consider pharmacists' recommendations, clearly document their responses and actions taken and, for any recommendations not followed, provide an adequate clinical justification.	PC		Needs improvement as part of overall improvement of medication rationales on CPPN.

<b>VIII.</b>	<b>DOCUMENTATION</b>  By 30 months from the Effective Date hereof, VSH shall ensure that an individual's records accurately reflect the individual's progress as to all treatment identified in the individual's treatment plan, consistent with generally accepted professional standards of care.	SigC	Improvement, but major gaps remain, as outlined throughout this report. Tasks remain the same.	Conduct Intra- and Interdisciplinary training sessions.  Conduct Qualitative Review of all disciplines.  Need to work on <ul style="list-style-type: none"> <li>– Information available to group leaders</li> <li>– Information available to IDT's</li> <li>– Information available to nursing staff, especially 2<sup>nd</sup> shift</li> </ul>
	By 30 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate assessments of the individual's progress relating to treatment plans and treatment goals.	SubC (2)		Transfer Notes need to explicitly indicate the patient was seen face-to-face by the psychiatrist or state when the last face-to-face evaluation took place.
<b>IX.</b>	<b>RESTRAINTS, SECLUSION AND EMERGENCY INVOLUNTARY PSYCHOTROPIC MEDICATIONS</b>  By 24 months from the Effective Date hereof, VSH shall ensure that restraints, seclusion, and emergency involuntary psychotropic medications are used consistent with generally accepted			

	professional standards of care.			
A.	By 18 months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols regarding the use of seclusion, restraints, and emergency involuntary psychotropic medications consistent with generally accepted professional standards of care. In particular, the policies and/or protocols shall expressly prohibit the use of mechanical restraints in a prone position and shall list the types of restraints that are acceptable for use.	SigC	<p>Review of:</p> <p>Database regarding patients who experienced the use of EIP (March 1 to August 31, 2008)</p> <p>Database regarding patients who met EIP Thresholds (March 1 to August 31, 2008)</p> <p>VSH Emergency Involuntary Procedure Report March 1 to August 31, 2008</p> <p>VSH Education and Training Report: Seclusion and Restraint Competency March 1 to August 31, 2008</p> <p>VSH Education and Training Report: 5-Day NAPPI Training March 1 to August 31, 2008</p> <p>VSH Seclusion and Restraint Performance-Based Competency</p> <p>NAPPI International Final Exam 2006</p> <p>Revised Certificate of Need (CON)</p> <p>Patient Debriefing following Emergency Involuntary Procedure Form</p> <p>Patient debriefing Audit: July 23, 2008</p> <p>EIP Threshold Monitoring Form</p> <p>EIP Documentation and Data Improvement Project</p> <p>EIP Staff Debriefing Tool</p> <p>Comparison Chart-Monthly Hours of Restraint per 100 Inpatient Hours, January 2006 to June 2008</p> <p>Comparison Chart-Monthly Hours of Seclusion per 100 Inpatient Hours, January 2006 to June 2008</p> <p>VSH EIP trends (March to August 2008):</p> <p>Episodes of Restraint (4-Point/5-Point)</p> <p>Hours of Restraint (4-Point/5-Point) per 1000 Patient Hours</p> <p>Mean Time (Hours) Per Episode of Restraint (4-Point/5-Point)</p> <p>Number of Patients in Restraints (4-Point/5-point)</p> <p>Episodes of Seclusion</p> <p>Hours of Seclusion per 1000 Patient Hours</p> <p>Mean Time (Hours) Per Episode of Seclusion</p> <p>Number of Patients in Seclusion</p>	

			<p>Episodes of Emergency Involuntary Medications Number of Patients Given Emergency Involuntary Medications Episodes of Emergency Involuntary Medications per 100 Patient Hours</p> <p>VSH reported that all new employees have received the five-day orientation NAPPI training during this review period. The facility reported 100% successful completion rate. The following table outlines the number of employees completing the training per month:</p> <table><tr><th>Month</th><th>#New employees</th></tr><tr><td>March</td><td>2</td></tr><tr><td>April</td><td>4</td></tr><tr><td>May</td><td>4</td></tr><tr><td>June</td><td>5</td></tr><tr><td>July</td><td>7</td></tr><tr><td>August</td><td>4</td></tr></table> <p>The facility’s data indicated that 186 staff members were required to take the annual review training during this review period. The facility reported that 95% of its staff completed this training (11 staff did not take the training due to leaves).</p> <p>VSH has implemented the following process improvements during this review period:</p> <p>1. Separate Certificates of Need (CON) forms for seclusion and for restraints were implemented to ensure adequate</p>	Month	#New employees	March	2	April	4	May	4	June	5	July	7	August	4	<p>Continue to:</p> <p>1. Provide data to show that all staff who monitor patients during the use of restrictive interventions has received initial and ongoing competency-based training pertaining to these interventions.</p> <p>2. Provide specific outline of any process changes regarding the use of EIP during the review period.</p> <p>3. Implement corrective actions to ensure documentation in the treatment plan (case formulation and current psychosocial functioning sections) of an interdisciplinary review of the use of seclusion and/or restraints and modification of the treatment plan, as needed, to reduce</p>
Month	#New employees																	
March	2																	
April	4																	
May	4																	
June	5																	
July	7																	
August	4																	

			<p>documentation of the circumstances leading to successive uses of seclusion and/or restraints.</p> <ol style="list-style-type: none"> <li>2. The RN assessment section of the CON was expanded to improve attention to food/drink, elimination, range of motion, vital signs and skin integrity.</li> <li>3. Training was provided to staff on the use of the revised CON process and conducted audits to verify the accuracy of documentation. A Performance Improvement project was initiated to ensure that documentation met compliance.</li> <li>4. A Patient Debriefing Form was developed and implemented to be completed following the use of seclusion and/or restraints. The form addressed the patient's understanding of what led to the incident, perception of the intervention and opinion of how well staff handled the event.</li> <li>5. A process was initiated to ensure that the interdisciplinary teams are notified of patients who have met thresholds regarding emergency involuntary procedures (EIP) and that interventions were provided to reduce the risk for these patients. The QA Department sends the psychology service a list of those patients meeting threshold criteria for EIP at the end of each week. Using a new EIP Monitoring Form, the Psychology service representative brings a list of the patients to the next weekly team rounds and facilitates discussion of whether changes are needed to the treatment plan to reduce the use of EIPs. A newly developed EIP Monitoring Form is used to document this discussion, including the rationale for any changes or no changes in the treatment plan.</li> <li>6. Using a grant from SAMHSA, the facility established a position of Coordinator of Alternatives to Seclusion and Restraints,</li> </ol>	<p>the risk.</p> <ol style="list-style-type: none"> <li>4. Implement corrective actions to ensure that the physician progress include adequate analysis of factors contributing to the EIP use and strategies to reduce the risk.</li> <li>5. Identify problematic trends/patterns regarding the use of EIP and provide corrective actions, as needed.</li> <li>6. Continue current efforts in the Emergency Involuntary Procedures Reduction Program (EIPRP).</li> </ol>
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			<p>schedules training in October 2008 on SAMHSA six core strategies to develop alternatives to restrictive interventions and initiated a Seclusion/Restraint Reduction Advisory Council to work with the facility's leadership in this area.</p> <p>The facility presented data showing that it has maintained its positive trends regarding the frequency of EIP use in the following categories:</p> <ol style="list-style-type: none"> <li>1. Episodes of restraints (4 point/5 point)</li> <li>2. Hours of restraint per 1000 patient hours (at or below national average)</li> <li>3. Mean time (hours) per episode of restraint</li> <li>4. Mean time (hours) per episodes of seclusion.</li> </ol> <p>VSH has assessed trends/patterns related to EIP during this review period. The facility noted a decrease in use of emergency involuntary procedures over the past six months. VSH reported that this decrease has been punctuated by increased use of EIP by three patients. The facility has provided a variety of behavioral interventions for these three patients, which has resulted in decreased use of restrictive interventions for these individuals (see VII.B.1).</p> <p>VSH has noted an increase in staff injuries and staff concerns about the effectiveness of NAPPI as a training model. A Request for Proposals was initiated to explore other training programs for Aggression/Violence Management. A review group is currently evaluating responses from vendors and will make a recommendation for an alternative training model to the Executive Director.</p> <p>This monitor reviewed the charts of 11 patients who have experienced the use of emergency involuntary procedures during this review period.</p>	
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The following tables outline these reviews:

MR#	Date of seclusion/ restraints threshold	Date of physician progress note	Date of treatment plan review
████	04/22/08	04/25/08	04/23/08
████	08/28/09	09/05/08	09/05/08
████	08/16/08	08/21/08	
████	04/14/08	04/15/08	05/12/08

	Date of involuntary medications threshold	Date of physi- cian progress note	Date of treatment plan review
████	03/25/08	03/27/08	03/28/08

	Date of seclusion/ restraints	Date of physi- cian progress note	Date of treatment plan review
████	08/24/08	08/29/08	09/25/08
████	05/28/08	06/05/08	06/05/08
████	04/16/08	04/17/08	05/13/08

			<table><tr><td>████</td><td>08/22/08</td><td>08/29/08</td><td>09/03/08</td></tr><tr><td>████</td><td>06/24/08</td><td>06/26/08</td><td>06/26/08</td></tr></table>	████	08/22/08	08/29/08	09/03/08	████	06/24/08	06/26/08	06/26/08	
████	08/22/08	08/29/08	09/03/08									
████	06/24/08	06/26/08	06/26/08									
			<table><tr><td></td><td>Date of involun- tary medication administra- tion</td><td>Date of phys- ician progress notes</td><td>Date of treat- ment plan review</td></tr><tr><td>████</td><td>04/16/08</td><td>04/17/08</td><td>05/13/08</td></tr></table>		Date of involun- tary medication administra- tion	Date of phys- ician progress notes	Date of treat- ment plan review	████	04/16/08	04/17/08	05/13/08	
	Date of involun- tary medication administra- tion	Date of phys- ician progress notes	Date of treat- ment plan review									
████	04/16/08	04/17/08	05/13/08									
			<p>The chart reviews showed that VSH has made some progress in the documentation of episodes of EIP in the physician progress notes, the CONs and Patient Debriefing Forms in most cases. However, in general, the chart reviews showed that VSH has to make further progress to correct the following findings of deficiencies:</p> <ol style="list-style-type: none"><li>1. There was incomplete and inconsistent documentation by the attending physicians of the factors that contributed to the use of seclusion and restraints and of timely and appropriate modifications of treatment to reduce the risk. The physician’s analysis of the use of restrictive interventions was often limited to a justification of why the use was necessary.</li><li>2. In general, the treatment plan reviews did not document the use of seclusion/restraints in the case formulation and/or current psychosocial functioning sections.</li></ol> <p>The treatment plans did not integrate the use of Behavioral Interventions that had implemented in a few cases.</p>									

B.	By 18 months from the Effective Date hereof, and absent exigent circumstances (i.e., when a patient poses an imminent risk of injury to himself or others), VSH shall ensure that restraints and seclusion:			
1.	are used in a reliably documented manner and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	SigC(1)	Same as in IX.A	Same as in IX.A
2.	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	SubsC(1)	Same as in IX.A	Same as in IX.A
3.	are not used as part of a behavioral intervention; and	SubsC(1)	Same as in IX.A	Same as in IX.A
4.	are terminated as soon as the individual is no longer an imminent danger to himself/herself or others, unless otherwise clinically indicated.	SubsC(1)	Same as in IX.A	Same as in IX.A
C.	By six months from the Effective Date hereof, VSH shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed medical professional of any individual placed in seclusion or restraints. VSH shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency based training on the monitoring of seclusion and restraints.	SubC (2)	Chart reviews showed that VSH has maintained compliance with this requirement.	

D.	By 18 months from the Effective Date hereof, VSH shall ensure the accuracy of data regarding the use of restraints, seclusion, or emergency involuntary psychotropic medications.	SigC	Same as in IX.A.	
E.	By 24 months from the Effective Date hereof, VSH shall revise, as appropriate, and implement policies and/or protocols to require the review within three business days of individuals' treatment plans for any individuals placed in seclusion or restraints more than three times in any four week period, and modification of treatment plans, as appropriate.	SubsC(1)	Same as in IX.A and B.1 above and XI A below.	Inconsistent. See B1 above.
F.	By 24 months from the Effective Date hereof, VSH shall develop and implement policies and/or protocols consistent with generally accepted professional standards of care governing the use of emergency involuntary psychotropic medication for psychiatric purposes, requiring that:	SigC	Same as in IX.A.	
1.	such medications are used on a time limited, short term basis and not as a substitute for adequate treatment of the underlying cause of the individual's distress;	PC	Same as above.	Need significantly improved rationales for medication use and all the accompanying considerations.
2.	a physician assess the patient within one hour of the administration of the emergency involuntary psychotropic medication; and	SigC		
3.	in a clinically justifiable manner, the individual's core treatment team conducts a review (within	SigC	Same as in IX.A above and XI.A below.	Same as in IX.A above and XI.A below.

	three business days) whenever three administrations of emergency involuntary psychotropic medication occur within a four week period, determines whether to modify the individual's treatment plan, and implements the revised plan, as appropriate.			
G.	By 18 months from the Effective Date hereof, VSH shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, or emergency involuntary psychotropic medications successfully complete competency based training regarding implementation of all such policies and the use of less restrictive interventions.	Subs C (1)	Same as in IX.A above.	Same as in IX.A above.
X.	<p><b>PROTECTION FROM HARM</b></p> <p>By six months from the Effective Date hereof, VSH shall provide the individuals it serves with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals, and require that staff investigate and report abuse or neglect of individuals in accordance with this Agreement and with Vermont state statutes governing abuse and neglect as found in 33 V.S.A. § 6901, et. seq. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. VSH shall not tolerate any mandatory reporter's failure to report abuse or neglect. Furthermore,</p>	SubC(1)	<p>Review of:</p> <p>VSH: Quality and Risk Management: Allegations of Abuse/Neglect/Exploitation reported to Adult Protection Services (AP), March 1 to August 31, 2008</p> <p>VSH Emergency Drill Summary Report, March 1 to August 31, 2008</p> <p>VSH Education and Training Report, March 01 to August 31, 2008</p> <p>Levels of Observation Policy, revised June 18, 2008</p> <p>Levels of Autonomy and Supervision Policy, September 18, 2008</p> <p>Safety Committee Infection Control Minutes August 26, 2008</p> <p>Summary of Program Performance: Safety, Risk Management and Infection Control Committee Report as of April 2008</p> <p>Psychiatric Emergency Response Policy, Draft</p> <p>During this review period, the Quality Manager (QM) has initiated a review of all event reports to</p>	1. Provide summary documentation of the Quality

	<p>before permitting a staff person to work directly with any individual, VSH shall investigate the criminal history and other relevant background factors of that staff person, whether full time or part time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at VSH.</p>	<p>identify any reports that may suggest possible abuse/neglect. The QM identified two incidents involving two patients and both cases were reported to Adult Protective Service (APS) as a result of this review.</p> <p>The Quality and Risk Management report (March 1 to August 2008) of VSH provided the following information regarding allegations of abuse/neglect/exploitation. The following is a summary of the data:</p> <ol style="list-style-type: none"> <li>1. All allegations of abuse/neglect/exploitation of patients: 29</li> <li>2. Information regarding substantiated allegations: 0</li> <li>3. Staff members involved in any allegation (11), including any staff involved in more than one allegation (1)</li> <li>4. Any injuries to patients (8)</li> <li>5. Repeat perpetrators (1)</li> <li>6. Repeat victims (1)</li> <li>7. Staff reassignment during the course of the investigation (0)</li> </ol> <p>None of the abuse/neglect allegations was substantiated by APS.</p> <p>During this review period, VSH identified a problematic pattern regarding patient elopements. The facility implemented a variety of corrective actions, including the following:</p> <ol style="list-style-type: none"> <li>1. Revision of the Levels of Autonomy and Supervision Policy to identify conditions for unit restrictions in high risk situations</li> <li>2. Development of MD Order Form and revision of Levels of Autonomy and Supervision Policy to require review and approval by the Medical Director and Executive Director for the three highest levels of patient autonomy.</li> </ol> <p>VSH did not remove staff pending the outcome of</p>	<p>Management reviews in the area of abuse/neglect/exploitation including, but not be limited to, the following:</p> <ol style="list-style-type: none"> <li>a. Systematic review of all event reports and identification of suspected abuse, neglect and/or exploitation</li> <li>b. Systematic review and analysis of all cases of substantiated abuse/neglect/exploitation for “lessons learned”</li> <li>c. Identification of patient and system patterns and trends</li> <li>d. Initiation and monitoring of corrective actions to reduce future risk.</li> </ol> <ol style="list-style-type: none"> <li>2. Continue documentation of the factors and circumstances that justify the facility’s decision not to remove/reassign staff in all situations of suspected abuse, neglect and/or exploitation</li> <li>3. Provide summary</li> </ol>
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			<p>the investigation in any of the allegations of neglect/abuse by staff during this review period.</p> <p>This monitor interviewed two patients [REDACTED] [REDACTED] who were involved in these allegations and the interviews did not reveal reason to suspect that removal of staff was necessary.</p> <p>During this review period, the facility conducted medical and environment of care emergency drills on an average of once a month, rotating the drills among the three shifts. The Director of education/training reviewed the drills with drill participants immediately after the drill to identify opportunities for improvement and any immediate measures needed to ensure safety of the patients. The director developed a summary of the findings, which was reviewed by the Safety and Risk Management Committee for further action/performance improvement plan development. Examples of findings and corrective actions include:</p> <ol style="list-style-type: none"> <li>1. Voice pagers were purchased and tested to improve performance during behavioral emergencies.</li> <li>2. Psychiatric Emergency Response policy was developed (draft) to provide guidance to nursing staff regarding expectations in responding to psychiatric emergencies.</li> <li>3. Blood pressure cuff and stethoscope were added to Treatment Mall Emergency Cart.</li> <li>4. Review with Treatment Mall staff their roles and responsibilities during the drill.</li> </ol> <p>Personal protective equipment has been added to all emergency carts and staff has been notified of the addition and informed of where to find the equipment</p>	<p>data that outline: a) all allegations of abuse/neglect/exploitation of patients; b) information regarding substantiated allegations; c) staff members involved in any allegation, including any staff involved in more than one allegation; d) any injuries to patients; d) repeat perpetrators; e) repeat victims; and f) staff reassignment during the course of the investigation.</p> <p>4. Continue systematic review of all medical emergency responses, including drills and corrective actions to address problematic trends/patterns. Provide summary outline of the response/drill scenario and corresponding corrective actions</p>

<b>XI.</b>	<b>INCIDENT MANAGEMENT</b>  By 12 months from the Effective Date hereof, VSH shall develop and implement, across all settings, an integrated incident management system that is consistent with generally accepted professional standards of care.			
A.	A. By 12 months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies and/or protocols, procedures, and practices shall require:	SigC	Review of: Risk Management Triggers/Thresholds Safety and Risk Management Committee Meeting Minutes (March, April-May and July 2008) VSH Falls Analysis March 01 to August 31, 2008 Patient Falls by Unit-Past Year Patient Falls All Units 2007-2008 Integrated Admission Assessment and Physician Certification: Fall Risk Assessment VSH Fall Prevention Policy June 18, 2008 VSH Quality Assurance Event Certification: Category F or Higher Events VSH Quality and Risk Management: Repeat Alleged Perpetrators and Repeat Alleged victims VSH Performance Improvement Project: Staff Injury Prevention VSH Safety and Risk Management Sub-Committee Meeting Minutes July 1, 2008 VSH Emergency Response Workgroup Meeting Minutes, March 18, March 27, April 10, April 24 and May 01, 2008 VSH Nursing Guidelines: Psychiatric Emergency Response (draft) VSH Request for Proposals (for alternatives to NAPPI training) Number of Events Related to Sharps Quality and Risk Management Report: Repeat Perpetrators and Repeat Victims in Patient-to-Patient Assaults	

			<p>VSH Decreasing Staff Injuries Report: Overview of Work Plan 2008</p> <p>VSH Fall Prevention Policy, June 18, 2008</p> <p>During this review period, VSH has expanded its categories of risk management triggers/thresholds. The current triggers and thresholds involve the following areas:</p> <ol style="list-style-type: none"> <li>1. Major injury</li> <li>2. Emergency involuntary procedures (EIP)</li> <li>3. Injuries related to EIP (staff or patient)</li> <li>4. Self-injurious behavior</li> <li>5. Suicidal gestures and attempts</li> <li>6. Falls</li> <li>7. Hospitalization</li> <li>8. Allegations of abuse, neglect or exploitation</li> <li>9. Metabolic disorders</li> <li>10. Intentional unsafe acts, as defined by Vermont Law and regulation</li> <li>11. Adverse drug reactions</li> <li>12. Sharps injury</li> </ol> <p>This outline includes three levels of interventions (clinical and treatment plan review, leadership review and consultation/continuing review). However, as mentioned in the previous report, the current levels of interventions do not specify the process and purpose of each level.</p> <p>VSH reported full implementation of its new electronic reporting system (Rosie/Quantros). Since the last review, the facility has delineated the following notification mechanisms:</p> <ol style="list-style-type: none"> <li>1. The Medical Director, the Executive Director and the Director of Nursing are notified of all events that are classified as category F (resulting in temporary harm to the patient) or higher.</li> <li>2. The manager of the area that relates to the event receives electronic notification of relevant events.</li> </ol>	<ol style="list-style-type: none"> <li>1. Provide outline of the process and purpose of different levels of interventions corresponding to the facility's triggers and thresholds of risk management.</li> <li>2. Specify the notification mechanism to ensure that the interdisciplinary team is notified in a timely manner of all events, including triggers/thresholds involving patients.</li> <li>3. Provide an outline of data regarding patient in injuries, staff injuries, patient-to-patient altercations without injuries, repeat perpetrators and repeat victims.</li> <li>4. Identify and analyze problematic trends and patterns, including an assessment of contributing factors and provide evidence of corrective actions based on performance improvement methodology.</li> </ol>
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			<p>3. The attending physicians and psychology department are notified of all thresholds regarding EIP use.</p> <p>The electronic event reporting system has tracked events in the following categories:</p> <ol style="list-style-type: none"> <li>1. Patient injuries</li> <li>2. Staff injuries</li> <li>3. Patient-to-patient altercations without injuries</li> </ol> <p>However, the current tracking system did not provide information regarding repeat perpetrators and repeat victims. Currently, this information is gathered manually.</p> <p>VSH has reviewed patient aggression data and identified that eight patients contributed to 70% of the aggressive behavior during this review period. Six of these patients have been discharged and the two patients who remain hospitalized have received behavioral interventions, with subsequent reduction in maladaptive behavior. The facility did not have sufficient data from the recently implemented electronic system regarding other trends/patterns.</p> <p>VSH has initiated a performance improvement project to address staff injuries. This project was triggered by data from the State of Vermont Safety Management Department showing a higher staff injury rate than expected. The facility reported 158 staff injuries between January and June 2008. Findings by VSH showed that 44% of the injuries were related to patient aggression, 20% were related to EIP use, 10% resulted from slips/strains/falls and the remaining injuries were unrelated to direct care of patients. Corrective measures included the following:</p> <ol style="list-style-type: none"> <li>1. Proposal for alternative methods of staff training regarding EIP use.</li> <li>2. Procurement of new lifting new lifting devices to facilitate better lifting techniques.</li> </ol>	<p>5. Provide a summary of all performance improvement projects during the review period, including a statement of the problem and how it was identified, purpose of the project, methodology, including team membership, outcome and follow up.</p> <p>6. Ensure that corrective actions regarding patient elopements do not result in undue restriction of the rights of some patients for treatment in the least restrictive setting.</p>
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			<ol style="list-style-type: none"> <li>3. New process of daily attending physician and registered nurse unit meetings to identify potential situations contributing to patient aggression and ensure early interventions.</li> <li>4. Plans to initiate new ergonomic training by the State of Vermont Safety department.</li> <li>5. Purchase of voice pagers and identification of early responders in the emergency response team to improve timeliness of behavioral emergency response.</li> </ol> <p>During this review period, VSH has initiated other performance improvement project, including the following:</p> <ol style="list-style-type: none"> <li>1. Patient Falls: The facility reviewed falls data from the previous six months and found no patterns/trends that raise concern. However, in an effort to improve performance, the facility developed a Fall Prevention Policy including a new assessment tool of Fall risk upon admission (as part of the integrated admission assessment), levels of intervention based on the risk score and process of post-fall evaluation and care.</li> <li>2. EIP practice: The facility addressed breakdown points in the data entry system regarding EIP use (units to hospital's electronic database), established a patient debriefing process, separated the CONS for seclusion and restraint to improve documentation of sequential use of seclusion and restraints and implemented revised CON packet instructions.</li> <li>3. Elopement response: During this review period, VSH had four patient elopements, with three incidents occurring within a two day period. To address this, the facility developed a variety of measures including revisions of the Levels of Autonomy and Supervision Policy to restrict patients to the units in specified high risk</li> </ol>	
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			<p>conditions (use of EIP, elopement and/or late return from authorized leave). The revised policy also required approval by the Executive Director and the Medical Director for the three highest levels of patient autonomy. While these measures appear to impinge on the rights of patients for treatment in the least restrictive environment, the facility is working on mechanisms to ensure that corrective measures will not result in patients being unduly restricted.</p> <p>This monitor reviewed the charts of the four patients who were identified as having met thresholds for repeat perpetrators [REDACTED] and [REDACTED] and the five patients who were identified as having met thresholds for repeat victims [REDACTED] during this reporting period.</p> <p>The review showed evidence of adequate behavioral interventions to address the individual's status in two cases [REDACTED]</p> <p>However, in all the charts reviewed, there was evidence of deficiencies in the following areas:</p> <ol style="list-style-type: none"> <li>1. Timely and proper notification of the teams regarding the thresholds;</li> <li>2. Adequate and timely review by the teams of the patient's status in the case formulation and psychosocial functioning sections of the treatment plan;</li> <li>3. Adequate and timely assessment by the teams of factors that contribute to high risk events, including the use of seclusion, restraints and/or emergency involuntary medications; and</li> <li>4. Adequate integration of behavioral interventions in the interdisciplinary treatment plan.</li> </ol>	
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1.	identification of the categories and definitions of incidents to be reported and investigated; immediate reporting by staff to supervisory personnel and VSH's executive director (or that official's designee) of serious incidents; and the prompt reporting by staff of all other unusual incidents, using standardized reporting across all settings;		Same as above.	
2.	mechanisms to ensure that, when serious credible allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with individuals pending the investigation's outcome;		Same as above.	
3.	adequate training for all staff on recognizing and reporting incidents;		Same as above.	
4.	notification of all staff when commencing employment and adequate training thereafter of their obligation to report incidents to VSH and State officials;		Same as above.	
5.	posting in each patient care unit a brief and easily understood statement of how to report incidents;		Same as above.	
6.	procedures for referring incidents, as appropriate, to law enforcement; and		Same as above.	
7.	mechanisms to ensure that any staff person, individual, family member, or visitor who, in		Same as Section X (Protection From Harm).	

	good faith, reports an allegation of abuse or neglect is not subject to retaliatory action by VSH and/or the State, including but not limited to reprimands, discipline, harassment, threats, or censure, except for appropriate counseling, reprimands, or discipline because of an employee's failure to report an incident in an appropriate or timely manner.			
B.	By 12 months from the Effective Date hereof, VSH shall review, revise, as appropriate, and implement policies and/or protocols to ensure the timely and thorough reporting of incidents to the Division of Licensing and Protection pursuant to 33 V.S.A. § 6901, et seq.		Same as Section X (Protection From Harm).	
C.	By 12 months from the Effective Date hereof, whenever remedial or programmatic action is necessary to correct a reported incident or prevent re-occurrence, VSH shall implement such action promptly and thoroughly and track and document such actions and the corresponding outcomes.		Same as A above.	
D.	By 12 months from the Effective Date hereof, records of the results of every investigation of abuse, neglect, and serious injury shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.		Same as Section X (Protection From Harm).	
E.	By 12 months from the Effective Date hereof, VSH shall have a system to allow the tracking and trending of incidents and results of actions		Same as A above.	

	taken. Trends shall be tracked by at least the following categories:			
1.	type of incident;			
2.	staff involved and staff present;			
3.	individuals involved and witnesses identified;			
4.	location of incident;			
5.	date and time of incident;			
6.	cause(s) of incident; and			
7.	actions taken.			
<b>XII.</b>	<b>QUALITY IMPROVEMENT</b> By 30 months from the Effective Date hereof, VSH shall develop, revise, as appropriate, and implement quality improvement mechanisms that provide for effective monitoring, reporting, and corrective action, where indicated, to include substantial compliance with this Agreement. The quality improvement methodologies shall be otherwise consistent with generally accepted professional quality improvement standards and shall:	SigC	Same as Section XI (Incident Management).	
A.	track data, with sufficient particularity for actionable indicators and targets identified in the Agreement, to identify trends and outcomes being achieved;			

B.	analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality improvement process. Such plans shall identify:			
1.	the action steps recommended to remedy and/or prevent the reoccurrence of problems;			
2.	the anticipated outcome of each step; and			
3.	the person(s) responsible and the time frame anticipated for each action step;			
C.	provide that corrective action plans are implemented and achieve the outcomes identified in the Agreement by:			
1.	disseminating corrective action plans to all persons responsible for their implementation;			
2.	monitoring and documenting the outcomes achieved; and			
3.	modifying corrective action plans as necessary; and			
D.	utilize, on an ongoing basis, appropriate performance improvement mechanisms to achieve VSH's quality/performance goals, including identified outcomes.			
<b>XIII.</b>	<b>ENVIRONMENTAL CONDITIONS</b>	SubC (2)	Safety and Risk Management Committee Meeting minutes Psychiatric Facility Safety Review	

	<p>By 12 months of the Effective Date hereof, VSH shall develop and implement a system to regularly review all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. The system shall attempt to identify potential suicide hazards and expediently correct them. Furthermore, VSH shall develop and implement policies and procedures consistent with generally accepted professional standards of care to provide for appropriate screening for contraband.</p>		<p>Unit Tours Mall Tour Certification reports Oral reports from CEO and COO</p> <p>Findings: Modify S/R policy to reflect procedure to obtain from patient any item that might prevent door from opening (since door opens in) has been done.</p> <p>Treatment Mall with exposed pipes is a safe environment within professional standards of care <i>except</i> for one area. Exposed pipes can be tolerated here while not so on a unit because:</p> <ul style="list-style-type: none"> <li>• Patients are not in areas with exposed pipes without staff at any time.</li> <li>• Exposed pipes are no more or less hazard than equipment routinely used by patients on the Treatment Mall that would not be available to them on the unit under the same consideration that staff are constantly present and supervising patients within their sight.</li> <li>• That patients are not in places in the Mall without staff present with patients in their sight is an inherent part of the mall process and understood at Treatment Malls nationwide.</li> <li>• The one exception to this is when a patient is in a bathroom. In this case, staff know the patient is in the bathroom, but do not go in the bathroom with the patient. Inspection of the patient bathroom on the Treatment Mall shows it is state of the art in terms of patient risk.</li> </ul>	<p>Address the pipes in the small area to the left of the staff office in the hallway. Since the door in this area is not used, VSH has several options as to how to address this.</p>
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## CONCLUSION

VSH has again made major gains since our last compliance visit. We acknowledge that the hard work done by VSH staff has resulted in the second Compliance Report with no finding of noncompliance (NC). The staff of VSH at all levels should be most pleased with the improvements their efforts have yielded to date, most particularly the Treatment Mall and the Psychology Department. As our report still indicates, there remains much to be done, but VSH continues to progress.

We look forward to our first visit in 2009, when we expect to see a hospital-wide integration of the Treatment Mall and the Treatment Teams.

Respectfully submitted,

Jeffrey L. Geller, M.D., M.P.H.

Mohamed El-Sabaawi, M.D.

JLG/MES:vab